CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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INTRODUCTION

The Virginia Medicaid Program is dependent upon the participation and cooperation of Virginia physicians who provide health care.

The physician is responsible for certifying that the service is medically necessary and that the treatment prescribed is in accordance with community standards of medical practice.

CLAIMCHECK

Beginning with claims received on or after July 1, 2001, Claim Check will be implemented by DMAS. ClaimCheck is a fully automated auditing system that verifies the clinical accuracy of claims submitted and reimbursed. DMAS will utilize ClaimCheck as a post-payment review of professional and laboratory claims. As a result of this auditing process, DMAS will make the necessary voids or adjustment of the claim(s) as a result of ClaimCheck.

MEDALLION

MEDALLION is a mandatory Primary Care Case Management program that enables Medicaid recipients to select their personal Primary Care Physician (PCP) who will be responsible for providing and/or coordinating the services necessary to meet all of their health care needs. MEDALLION promotes the physician/patient relationship, preventive care, and patient education while reducing the inappropriate use of medical services. The PCP serves as a gatekeeper for access to most other non-emergency services that the PCP is unable to deliver through the normal practice of primary care medicine. The PCP must provide authorization for any other non-emergency, non-exempted services in order for another provider to be paid for services rendered. To provide services to a MEDALLION recipient, prior authorization from the recipient's PCP is required. Before rendering services, either direct the patient back to his or her PCP to request a referral or contact the PCP to inquire whether a referral is forthcoming. The PCP's name and telephone number is listed on the recipient's MEDALLION identification card. Refer to the MEDALLION section of this manual for further details on the program

PHYSICIAN'S ROLE IN RENDERING SERVICES

Physician services are those services provided within the scope of professional license. These services must be rendered by or under the direct and personal supervision of an individual licensed under State law and are to be billed by the physician who renders the service. If a specialist orders services for the recipient, the MEDALLION PCP must have made the referral to the specialist. The specialist must maintain documentation of

coordination of services with the MEDALLION PCP. In those instances where coverage is provided by a physician other than the patient's regular physician, the actual provider of services must be a participating Medicaid provider in order to bill for services performed even though he or she may not be the patient's regular physician (e.g., "covering physicians" must bill for the services they personally render).

Additionally, physicians are required to maintain records detailing the nature and scope of the health care provided to Medicaid recipients. Entries in patient records must be signed and dated by the physician rendering the service. Care rendered under the direct, personal supervision of the participating provider must be countersigned by that provider.

Out-of-State Physicians

As stated in Chapter II of this manual, any provider of services must be enrolled in the Virginia Medicaid Program prior to billing for any services provided to Virginia Medicaid recipients. Should an out-of-state, non-participating physician render services to an eligible recipient, the provider must request a participation agreement by writing:

FIRST HEALTH Services - Provider Enrollment Unit
The Banks Brothers Building
4461 Cox Road, Suite 102
Glen Allen, Virginia 23060-3331

Telephone requests will also be considered; call (804) 270-5105. (Note: If specific physician services required by the recipient are available in Virginia within a reasonable distance from the recipient's home, the recipient should not be referred to an out-of-state physician.)

Physician's Role in the BabyCare Program

The physician is the critical link between the high-risk pregnant woman or infant and the services available through the BabyCare program. The physician is responsible for identifying potential or existing problems through the systematic review of the pregnant woman or infant's medical/obstetrical/developmental conditions, as well as lifestyle and environmental factors, and making referrals for care directed at preventing or ameliorating those problems. The physician documents the existence of any risk on the Maternity or Infant Risk Screen (DMAS-16 or DMAS-17), which then entitles the recipient to a formal case management process, including prenatal services and pediatric care. (See "**Exhibits**" at the end of the chapter for a sample of these forms.) The hospital physician is especially important in the identification of infants, at the time of delivery, who are at risk for a medical, social, or nutritional condition that may affect the development of the child. While this process helps identify those recipients who are at risk, it does not obligate the physician to assume overall medical responsibility for supervision of the recipient.

The physician may also play an important role through choosing to participate as a member of the BabyCare team which develops the plan of care and provides maternal and infant case management throughout the pregnancy and 60 days postpartum and up to age two for infants. The BabyCare team consists of the primary care provider (a physician, nurse practitioner, or nurse midwife), the care coordinator (a social worker or registered nurse) who provides maternal and infant case management, and other clinicians (a registered dietitian and certified instructors) who provide nutritional and educational assistance to the recipient. For additional information, refer to the BabyCare Manual.

Physician's Role in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

The EPSDT program provides preventive health care to individuals (from birth up to age 21) eligible for medical assistance. The purpose of the EPSDT program is prevention of health

problems through early detection, diagnosis, and treatment. The goal of the EPSDT program is to promote a medical home so recipients can receive both sick and well care from the same provider. The required screening components for an EPSDT examination are to be completed according to the time frames on a periodicity schedule that was developed by the American Academy of Pediatrics, the Virginia Department of Health, and the Virginia Department of Medical Assistance Services.

The EPSDT screening is a comprehensive examination which consists of the following required components: an unclothed physical, physical/mental evaluation, growth and nutrition assessment, developmental assessment, vision assessment, hearing assessment, dental assessment, laboratory procedures, immunizations, and anticipatory guidance.

In addition to the complete EPSDT screening, practitioners can perform three components (vision, hearing, and dental assessments) as partial screenings whenever such an assessment is indicated.

Any physician enrolled as a provider in the Medicaid Program to provide physician or clinic services can provide EPSDT screening services. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP). A separate participation agreement is not required. See Supplement B to this manual for details on EPSDT coverage and billing.

Physician's Role in Inpatient Hospital Services

Medicaid covers hospital services for eligible Medicaid recipients when medically necessary. The care and treatment of the patient must be under the direction of a licensed physician or dentist with hospital staff affiliation. If a specialist orders services for the recipient, the MEDALLION PCP must have made the referral to the specialist. The specialist must maintain documentation of coordination of services with the MEDALLION PCP.

Refer to the section on "Certification and Recertification" in Chapter II and see the section "Hospital Visits" in this chapter.

Physician's Role in Home Health Services

Home health services provide periodic nursing care under the direction of a physician. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP). If a specialist orders services for the recipient, the MEDALLION PCP must have made the referral to the specialist. The specialist must maintain documentation of coordination of services with the MEDALLION PCP. Such services are provided by participating home health agencies and can be used effectively by the physician for post-hospital care and periodic nursing care. The Medicaid Program will reimburse home health agencies for necessary services prescribed by the physician. See the *Home Health Manual* for additional information.

PHYSICIAN'S ROLE IN THE PRESCRIPTION DRUG PROGRAM

Prescription drugs are covered under the Virginia Medicaid Program. The physician's normal procedure for prescribing drugs should be followed. However, the prescriber's Medicaid provider number must be included on all prescriptions for Medicaid recipients including those serviced by Health Maintenance Organizations (HMOs).

The prescribing of drugs should be in accordance with community standards of medical and pharmacy practices and consistent with economy. Virginia Medicaid requires the use of generic drugs where possible. Physicians may specify a brand name only when it is medically necessary. In acute illnesses, prescribed drugs should be limited to the quantity needed for the course of treatment for the illness. Maintenance drugs for chronic illnesses should be prescribed in quantities according to treatment needs.

Coverage and Limitations

Prescription services are provided to Medicaid recipients as described below.

Legend drugs are covered except for the following:

- OBRA 90 non-rebated drug products - Drugs distributed or manufactured by certain drug manufacturers or labelers that have not agreed to participate in the Federal Drug Rebate Program (effective April 1, 1991);
- Agents used for anorexia or weight gain;
- DESI (Drug Efficacy Study Implementation) drugs considered by the Food and Drug Administration (FDA) to be less than effective. Compound prescriptions which include a DESI drug are not covered;
- Drugs which have been recalled;
- Vaccines for routine immunizations except pharmacist-administered vaccines under the protocol specified in the *Pharmacy Manual*;
- Agents used to promote fertility;
- Experimental drugs or non-FDA-approved drugs;
- Expired drug products dispensed after the labeled expiration date of the product;
- Hair growth products; and
- Agents containing hydroquinone or its derivatives which are used solely for depigmentation of the skin.

Specific Requirements for Individual Legend Drugs

- Clozaril (Clozapine) - is authorized when the following conditions are applicable (effective July 25, 1991**)**:
    - Medicaid-eligible recipients must have a Clozaril National Registry number;
    - Each registered case with a number is required to comply with the Food and Drug Administration (FDA) approved indications for weekly blood and prescription monitoring; and
    - A monitoring fee will be paid pharmacies on a weekly basis based on the current dispensing fee rate and the use of 9999999275 for 100mg and 9999999276 for 25mg for the submission of claims.
- Total Parenteral Nutrition (TPN) - is authorized when the following conditions are applicable as a **sole source of nutrition only when**:
    - There is a physician's statement of medical necessity in the patient record indicating the diagnosis with a brief clinical history;
    - The short- and long-term plans for the requested service are given; and
    - The name and address of the pharmacy supplying the prescription are given.
- Growth Hormone - is authorized when the following conditions are applicable:
    - There is a physician's statement of medical necessity in the patient record indicating the diagnosis with a brief clinical history;
    - The short- and long-term plans for the requested service are given; and
    - The name and address of the pharmacy supplying the prescription are given;
- Norplant - is reimbursable when dispensed for physician administration **only**.
- Drugs for Treating Erectile Dysfunction - Effective for prescriptions dated February 1, 2000, and after, Virginia Medicaid will pay for FDA-approved drugs for treating erectile dysfunction for men age 21 or older. Coverage will be limited to 4 dosage units per consecutive 30-day period.

Coverage of Weight Loss Drugs

Effective for dates of service on and after July 1, 1997, anorexiant drugs may be covered for recipients who meet specific disability criteria for obesity as established by the Social Security Administration (SSA) and in effect on or before April 7, 1999, and whose condition is certified as life-threatening by the treating physician. Effective for dates of service on and after September 1, 1999, all FDA-approved weight loss drugs may be covered for recipients

who meet the same criteria as for anorexiant drugs. Such coverage shall be provided only when prior authorization has been granted by the Director of Medical Support or his designee, based on a certificate of medical need and the supporting documentation.

Providers should consider the following factors in determining the need for the use of anorexiant drugs:

- Conformity of the patient's condition to the Social Security Administration's (SSA) definition of obesity as a disability as found in *Disability Evaluation Under Social Security* (SSA Publication 64-039), Part III, § 9.09, which requires weight in excess of 100 percent of the SSA defined desired level and a concurrent condition defined in the same section of SSA definitions relating to impairment by virtue of endocrine systems and obesity;

- Presence of a certified life-threatening condition, documented by the treating physician;

- Compliance with General Regulation 18 VAC 85-20-90. *Pharmacotherapy for Weight Loss* as set forth by the Virginia Board of Medicine, as delineated in its *Board Briefs*, Newsletter #52 (Spring 1997);

- The manufacturer's directions for the specific drug's therapy; and

- Assessment of the risk-benefit ratio related to the patient's commitment to compliance in treatment.

Documentation presented for consideration should include, but is not limited to:

- Age;
- Height;
- Weight;
- Psychiatric or psychosocial evaluation;
- Documented medical record evidence of functional disability;
- Documented medical evidence of previous conservative medical management;
- Documentation that other causes of obesity have been ruled out (for example, hypothyroidism);
- Documentation of the extent of concurrent medical problems; and
- Documentation by the attending physician certifying the determination that the patient's life is at risk due to obesity.

(See "Exhibits" at the end of the chapter for the SSA definition of obesity and the Board of Medicine Regulation.) Additional copies may be obtained, upon request, through Medical Support Services by calling (804) 786-8056 or sending a FAX to (804) 786-0414.

Requests for prior authorization must contain the patient's full name and 12-digit Medicaid identification number. The prescriber must also provide the name and complete address of the pharmacy which will be providing the service. Send these requests to the attention of:

Director of Medical Support Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Procedures for Documentation Related to Amphetamines Used for Attention Deficit Disorders and Narcolepsy, Growth Hormone, and Total Parenteral Nutrition Services

Medicaid has specific procedures to be used when documenting medical necessity for 1) amphetamines used for attention deficit disorders or narcolepsy, 2) growth hormone, and 3) total parenteral nutrition (TPN) services provided by pharmacies.

Providers do not need to submit the documentation of medical necessity to the Director of Medical Support Services at Medicaid, but prescribers must document the prescription order and the medical necessity of the services in the patient's medical record. Anorexiants used to treat obesity require prior authorization in compliance with the Virginia *State Plan for Medical Assistance*. The *State Plan* also excludes payment for products used for weight gain. Medicaid will monitor compliance with these requirements through the post-payment review process.

Prescribers must document the prescription order in the patient's medical record and verify the medical necessity by providing a description of the related clinical symptoms and diagnosis in the record. These documentation procedures should expedite the provision of services to Medicaid recipients. Medicaid may use its post-payment utilization review to verify compliance with these requirements.

Prescriber ID Number

To be in compliance with current Medicaid requirements, prescription orders for Medicaid recipients must bear the prescriber's Medicaid number. Claims for prescription services submitted by pharmacies provide the basis of several Medicaid programs, including Drug Utilization Review, Provider Review, and the Disease State Management Initiative. Inaccurate or incomplete data related to prescriber identification may negatively impact the success of these programs.

Health Maintenance Organization (HMO) providers must affix the appropriate Medicaid provider number to all prescription orders for Medicaid recipients.

Denial for Payment of Antiulcer Drugs Used Beyond Acute Dose Limit

The POS system will edit all pharmacy claims in the antiulcer category for correct dose and duration. The criteria used will be those defined by the DMAS Drug Utilization Review Board (DUR Board). The criteria contain information about correct dose for acute treatment and for maintenance therapy, as well as the appropriate duration of treatment in the high-dose categories. Dose calculations will be based on the days' supply entered by the dispenser. If the use of a product exceeds the maximum dose or duration limit, a message will appear on the user's screen indicating that payment is denied. If there is a valid reason

for continued high-dose use, the pharmacist must enter the appropriate override code into the system to document the reason.

Maintenance level use of antiulcer products will be screened for duration of use. Appropriate prescriber consideration must be given to continued dosing at maintenance levels beyond the manufacture's recommendation. Prescribers are encouraged to consider diagnostic testing or treatment for *H. Pylori* in the determination of continued treatment in refractory cases.

In the following circumstances, pharmacist-initiated overrides may be employed by using the appropriate code.

Valid reasons for the overrides are:

- Initial Therapy;
- Gastroesophageal Reflux Disease (GERD);
- Pathological Hypersecretory Syndrome;
- Zollinger-Ellison Syndrome;
- Unhealed Ulcer (gastric, duodenal, peptic);
- History of Upper GI Bleeding; and
- Erosive Esophagitis.

<u>Early Refills and Therapeutic (Class) Duplication in Certain Drug Categories</u>

Medicaid has an early refill denial edit and therapeutic (class) duplication edit as an enhancement of the Medicaid Prospective Drug Utilization Review (ProDUR) activities requirement. These POS edits expand ProDUR activities to include the denial of unjustified requests for early prescription refills or therapeutic (class) duplicate products. In unusual situations, a mechanism has been provided for override of the denial.

"Early refill" is defined as "when a prescription refill is requested before 75% of the calculated days' supply has elapsed for the previously filled prescription."

Additionally, a denial edit for therapeutic duplication will occur when a product in the same therapeutic drug class as a concurrently utilized product (e.g., concurrent use of two calcium channel blockers) is billed. The following groups of drugs will be subject to therapeutic duplication alerts:

- ACE Inhibitors;
- Antidepressants;
- Anti-Ulcer;
- Benzodiazepines;
- Calcium Channel Blockers;
- Cardiac Glycosides;
- Diuretics; and
- Non-Steriodal Anti-Inflammatory Drugs (NSAIDS).

An early refill claim or a therapeutic duplication within certain drug classes will be denied payment.

In the following unusual circumstances, the pharmacist may override the denial:

A. Only the following reasons may be used as justification for override of early refill edits:

1. **"Temporary Exemption" -** Need determined by travel distance, transportation availability, or travel out of the area;
2. **"Missing Medication: -** Waste, spilled, lost, stolen, destroyed, or damaged drug supply;
3. **"Data Entry Error (days' supply)" -** Keying error or underestimation of use pattern; and
4. **"Clinical Justification" -** Dose increase authorized by the prescriber, etc.

B. Only the following reasons may be used as justification for override of the therapeutic duplication edit:

1. **"Original Drug Discontinued. New Drug Ordered." -** Discontinued use of one drug and subsequent new prescription issued in the same therapeutic drug class (e.g., substitution of one calcium channel blocker for another); and
2. "**Physician Contacted, Deems Duplicate Therapy Necessary." -** Pharmacist's professional judgment still must be used to ensure the patient will not be at risk from such duplication.

<u>Pharmacy Coverage for Outpatients Using Certain Over-the-Counter (OTC) Products</u>

The purpose of this initiative is to allow the use of cost-saving alternatives in the prescription program, not to allow general coverage of all OTC products. Therefore, these products should only be prescribed for outpatients *when the provider otherwise would have used a more expensive legend product*. Note that it is possible to titrate the dose of many of these agents. In this manner, health professionals may choose to adjust the dose or product to suit the individual needs of the patient.

The choice of whether or not to use these additional products will be determined by the patient's prescribing health care provider. This expansion of over-the-counter drug coverage in the outpatient population does not affect the current coverage standards for categories of drugs included for over-the-counter coverage in the nursing facility environment.

The additional over-the-counter categories of products available for selected outpatients are (effective for dates of services on and after February 1, 1997):

- Analgesics, oral;
- Antacids;
- Antidiarrheals;
- Antifungals, topical;
- Antihistamines;

- Anti-infective agents, vaginal;
- Anti-inflammatory agents, oral;
- Antiulcer preparations;
- Hematinics;
- Hydrocortisone, topical;
- Laxatives, Bulk Producers, Stool Softeners;
- Pediculocides/Scabicides;
- Vitamins, Pediatric (in established deficiencies);
- Vitamins, Prenatal; and
- Vitamins or Minerals for dialysis patients.

Medicaid will handle requests for over-the-counter products in the same manner as prescriptions. The order may be written as a prescription or transmitted to the pharmacy by any other means which complies with the regulations of the Board of Pharmacy.

Products covered under this program must be supplied by companies participating in the HCFA Medicaid rebate program.

Non-Legend Drugs

Non-legend drugs (over-the-counter), both covered and non-covered, are described below:

- Coverage is allowed for family planning drugs and supplies and insulin for all recipients, and syringes and needles for recipients, except those residing in nursing facilities.

- See above for specific therapeutic categories for outpatients.

- Specific therapeutic categories, which are covered for recipients residing in nursing facilities are:

    - Analgesics;
    - Antacids;
    - Antidiarrheal preparations;
    - Antivertigo and antinauseant preparations;
    - Cough and cold preparations;
    - Dermatologicals;
    - Hemorrhoid preparations;
    - Laxatives;
    - Ophthalmic and otic preparations; and
    - Vitamins, minerals, and hematinics.

- The following items are not covered by the Medicaid Pharmacy Program:

    - Dietary items, such as sugar or salt substitutes;

    - Enteral nutrition;

- Intradialytic Parenteral Nutrition (IDPN) - Certain dialysis centers use IDPN as an adjunct to dialysis. IDPN in the form of amino acids, vitamins, minerals, and other nutrients administered during the dialysis session is not covered by Virginia Medicaid;

- Supplies, including (but not limited to) antiseptics (e.g., hydrogen peroxide, Merthiolate, tincture of iodine, Mercurochrome, rubbing alcohol, antiseptic soaps, boric acid), first aid preparations (e.g., Band-Aids, gauze, adhesive tape), and miscellaneous supplies, such as cervical collar, asepto syringe, IV sets, and support stockings;

    - **EXCEPTION**: Medically necessary medical supplies are covered when provided under the intensive rehabilitation or home health services programs and through EPSDT or under the Technology-Assisted or AIDS Waiver programs. Medicaid recipients requiring ostomy, dialysis, or oxygen supplies do not have to be receiving services from one of the above programs for coverage of these supplies. (Effective February 1, 1992)

- Expired drug products dispensed after the labeled expiration date of the product;

- Hair growth products;

- Personal items, including (but not limited to) dentifrices, dental adhesives, toiletries, and other items generally classified as cosmetic; mouthwash and gargles; shampoos (non-legend) and soaps; cough drops; depilatories, suntan lotion, and hair bleaches;

- Products used for cosmetic purposes;

- Patent medicines (e.g., Doan's Pills), except as listed on the covered drug list, when used as a less expensive alternative to a prescription only product; and

- Alcoholic beverages.

Control Schedule V drugs are covered as legend regardless of the quantity dispensed.

Multiple Source Drugs and Brand Necessary Certification

Under the authority of 1902(a) (3) (A) and the regulations in 42 CFR 447.332, the Health Care Financing Administration (HCFA) establishes a specific upper limit for a multiple source drug if the following requirements are met:

- If all of the formulations of the drug approved by the Food and Drug Administration (FDA) have been evaluated as therapeutically equivalent in the current edition of the publication *Approved Drug Products With Therapeutic*

Equivalence Evaluations (including supplements or in successor publications); and

- If at least three suppliers list the drug, which has been classified by the FDA as category "A" in its publication *Approved Drug Products With Therapeutic Equivalence Evaluations* (including supplements or in successor publications); in current editions (or updates) of published compendia of cost information for drugs available for sale nationally (e.g., *Red Book*, *Blue Book*, *Medi-Span).*

Consistent with the policy requiring the use of generic drugs, Medicaid will pay no more than the upper limit for multiple source drugs for which a specific limit has been established unless a physician certifies in his or her handwriting that a specific brand is "brand necessary" for a particular recipient. The handwritten phrase "brand necessary" must appear on the face of the prescription. A dual line prescription form does not satisfy the certification requirement. A check-off box on a form is not acceptable. The "brand necessary" documentation requirement applies to telephoned prescriptions as well. This certification authorizes the pharmacist to fill the prescription with the requested brand name product. The physician should not certify "brand necessary" on the basis of the patient's request alone, but only, if there are valid medical reasons (allergic reaction to the active ingredient, for example) documented in the patient's record. Utilization will be reviewed. In addition, the Department of Medical Assistance Services has established a Virginia Maximum Allowable Cost for some multiple source drugs listed in the Virginia Voluntary Formulary which are not designated as federal maximum allowable drugs. Again, unless the physician follows the procedures outlined above for specifying a brand necessary drug, the Virginia Maximum Allowable Cost per unit will be used to determine the allowable payment.

Copayment on Drugs

The following recipients are **always exempt** from copays:

- **Children Under 21 Years Old -** Identified by a Special Indicator Code of "A" on the Medicaid card; and

- **Individuals Receiving Long-Term Care Services or Hospice Care -** Identified by a Special Indicator Code "B" on the Medicaid card.

The following services are **never subject to copay**:

- Services delivered in the emergency room;

- Emergency services delivered in other settings;

- Pregnancy-related services; and

- Family planning services (including family planning drugs).

All other recipients have a Special Indicator Code of "C" on their cards and **are responsible for a $1.00 copayment for each multi-source generic, and $2.00 for each brand prescription or refill for dates of service on or after September 1, 2002**.

Services to a recipient cannot be denied solely because of his or her inability to pay any applicable copayment charge. This does not relieve the recipient of the responsibility to pay, nor does it prevent the provider from attempting to collect any applicable copayment from the recipient. Providers are not required to collect the copayment. However, Medicaid will deduct the copayment amount from the provider's remittance. NOTE: Prescribing physicians should indicate "PREGNANCY" on the prescription form for prescriptions related to the pregnancy for pregnant women.

Drug Coverage Policy and Procedures for Recipients in Medicaid Health Maintenance Organizations

Federal law states that recipients enrolled in Medicaid Health Maintenance Organizations (HMOs) must have access to the same services available to Medicaid recipients in the fee-for-service program. The Medicaid fee-for-service program uses an open formulary.

Contracted HMOs in MEDALLION II and *Options* are permitted to establish their own formularies. However, HMOs must have in place prior authorization procedures to allow providers access to drugs outside of this formulary, if medically necessary, and if they would have been covered by Medicaid for fee-for-service recipients.

If the prescribing provider does not wish to prescribe a drug on the HMO's formulary, he or she must follow the HMO's Medicaid-approved special authorization procedures, and advise the recipient that there may be a delay.

The HMO must follow its Medicaid-approved special authorization procedures within its prescribed time frame and promptly notify both the physician and the pharmacy providers of its decision. In accordance with Section 1927 of Title XIX of the Social Security Act, the HMO must respond to the special authorization within 24 hours. The HMO's response may be a request for additional information from the provider if this is needed to make the decision.

If the drug is prescribed for an "emergency medical condition," the HMO must authorize at least a 72-hour supply of the drug to allow the HMO time to make a decision. An "emergency medical condition" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain, such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the recipient (or unborn fetus of a pregnant recipient) in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

In accordance with the Code of Federal Regulations (CFR 447.331(c)(3)), HMOs must provide brand name drugs when the prescribing provider certifies in his or her own handwriting that a specific brand is medically necessary for a particular recipient. A check-off box on the prescription is not acceptable. The prescribing provider must indicate "brand necessary" in his or her own handwriting. HMO payment authorization systems cannot override these requests with generic substitutes.

If coverage for this or any service is denied by the HMO, it is the HMO's responsibility to inform the recipient of his or her rights and the procedures for an appeal.

The Managed Care Clinical Coordinator at the Department of Medical Assistance Services should be notified of any instances of non-compliance with these procedures at (804) 786-7956.

Coverage of Protease Inhibitors

Federal law requires states to cover protease inhibitors for Medicaid-eligible persons with HIV/AIDS. Medicaid fee-for-service recipients receive these drugs through their Medicaid coverage. Therefore, this class of drugs must be available to Medicaid recipients enrolled in HMOs.

Drug Utilization Review Program

State and federal legislation created the directive for the Virginia Medicaid Drug Utilization Review (DUR) program. The purpose of the OBRA 90 DUR Program is to ensure that prescriptions for outpatient drugs are appropriate, are medically necessary, and are not likely to cause adverse results. OBRA 90 further requires that the DUR Program be designed to educate physicians and pharmacists to reduce the frequency of patterns of fraud, abuse, gross overuse or inappropriate or medically unnecessary care. DMAS has established a DUR Board to: review and approve drug use criteria and standards for both retrospective and prospective DURs; apply these criteria and standards in the performance of DUR activities; review and report the results of DURs; and recommend and evaluate educational intervention programs. The DUR Board has selected DUR criteria that are representative of clinically important issues. The focus of these criteria is on high-risk, high-volume, and high-cost drugs.

Under the OBRA 90 federal mandate, retrospective DUR is required for outpatients. However, because of a State legislative mandate for nursing facility retrospective DUR, nursing facility patients are also included in the retrospective component of the DUR Program. The criteria used for the nursing facility population is tailored to the needs of the elderly; the data for the outpatient and nursing facility populations will be analyzed and reported separately.

Prospective DUR (prospective review, patient counseling, and patient profiling) is required only for outpatients. Patient counseling is not required for inpatients of a hospital or an institution where a nurse or other caregiver authorized by the Commonwealth is administering the medication.

The impact of the DUR Program on Medicaid providers varies. The retrospective component is primarily focused on prescribing patterns and is likely to have more of an effect on physicians and other prescribing providers. The pharmacist is responsible for performing the activities required for the prospective component. As a result, pharmacy providers will be affected by prospective DUR to a greater degree than prescribing providers.

PROGRAM COVERAGE

Introduction

The Medicaid Program is designed to assist eligible Medicaid recipients in obtaining medical care within the guidelines specified in this manual and the *State Plan*. Allowable Medicaid reimbursement is based upon medical necessity. Medicaid defines "medically necessary services" as those services that are covered under the *State Plan* and are reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member. Coverage may be denied if the requested service is not medically necessary according to the preceding criteria or is generally regarded by the medical profession as experimental or unacceptable.

Scope

"Physician Services" are defined as services provided within the scope of a physician's professional license as defined by Virginia law. These services must be rendered by or under the direct and personal supervision of an individual licensed under State law to practice as a doctor of medicine (M.D.), or doctor of osteopathy (D.O.), and are to be billed by the physician rendering the service. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP).

In billing for covered services, the Department of Medical Assistance Services requires the use of codes and definitions published in the *Physicians' Current Procedural Terminology, Fourth Edition* (CPT), which has been incorporated into the federal Health Care Financing Administration Common Procedure Coding System, or HCPCS (for clarity, this combined coding system is identified as "CPT/HCPCS"). The physician is to select from the CPT/HCPCS book the procedure code which most appropriately describes the service rendered and documented. Definitions and descriptions of levels of service contained in the introduction to the CPT/HCPCS are to be used when determining the level of service to be billed. These same definitions and descriptions will be used to evaluate documentation during Program audits of medical records. (See also the section on documentation.)

Copies of the *Physicians' Current Procedural Terminology, Fourth Edition* (CPT) may be obtained from:

Order Department: OP054192
American Medical Association
P. O. Box 10950
Chicago, Illinois 60610

Payments for physician services are made only when medically necessary for the diagnosis and treatment of an illness, injury, restoration of a body function, family planning, or maternity care.

Patient records must document fully the extent of all services which are rendered and billed to the Program. These records must be made available for inspection by an authorized Program representative and/or federal personnel when requested. Failure to do so may result in termination of the provider participation agreement.

Benefit and Coverage Limitations

The following services are covered under the Virginia Medicaid Program only when provided in accordance with the limitations and requirements specified.

Anesthesia

An anesthesiologist may submit charges for anesthesia administration only under the following conditions:

- When the cost of the physician's services is not included as an expense item in the hospital reimbursable cost report and the hospital makes no charge for the service;
- The anesthesia is personally administered by a physician who remains in constant attendance during the surgery; or
- The anesthesia is administered by a nurse anesthetist or technician who is employed by the anesthesiologist, and who is under the anesthesiologist's direct personal supervision.

Anesthesiologists' services are paid for by units of time - **one unit for each 15 minutes or fraction thereof** for the surgical procedure performed. When billing for anesthesiology, use the CPT/HCPCS anesthesia code for the procedure performed and insert the time units in Locator 24G of the HCFA-1500 (12-90) claim form. The base unit (preoperative consultation with the patient) is included in the reimbursement and should not be included in the units of time for the procedure. Example: An anesthesiological procedure required one hour and 45 minutes. Locator 24G would properly show seven (7) units. (NOTE: regarding the administration of epidural blocks, only those units of time during which the anesthesiologist directly attended the patient will be paid.)

Chemotherapy

The combination of several procedure codes is required in order to bill for the administration of chemotherapy treatments:

- The appropriate chemotherapy administration procedure codes, 96400-96549 (See Appendix F for a detailed listing.)
- The appropriate HCPCS codes for chemotherapy drugs, J9000-J9999 (See Appendix E for a detailed listing.)

- The appropriate office visit (if applicable), procedure codes 99201-99215 (See the CPT/HCPCS book for additional listing.)

The chemotherapy injection or infusion procedure codes are independent of the office visit. These codes describe chemotherapy administration by a qualified assistant under the supervision of a physician or by the physician and include the necessary administration supplies and mixing agent. The chemotherapy drug procedure codes describe the drug administered and do not include the chemotherapy administration or the office visit, if applicable.

Physicians administering chemotherapy in their offices may bill for the appropriate chemotherapy administration (procedure codes 96400-96549), the appropriate procedure code for chemotherapy drugs (J9000-J9999), and the appropriate office visit (procedure codes 99201-99215), if applicable.

Concurrent Care

Payment for concurrent care will only be considered when more than one physician is actively engaged in the patient's treatment. Each physician must sufficiently explain the condition or conditions for which treatment was rendered through the use of an attachment to the Health Insurance Claim Form, HCFA-1500 (12-90) billing invoice. Enter procedure modifier “75” (“concurrent care”) in Locator 24D of the claim form.

Consultations

A service rendered by a physician whose opinion or advice is requested by another physician for the further evaluation or treatment or both of the patient is considered a consultation. If such a service is provided and Medicaid is billed for this type of service more than once within a six-month period, justification must be furnished as an attachment to the HCFA-1500 (12-90) claim form, and individual consideration requested. Enter "ATTACHMENT" in Locator 10D and enter procedure modifier "22" ("Unusual Service") in Locator 24D of the HCFA-1500 (12-90) claim form. Consultation services should be billed using the appropriate CPT/HCPCS code. If the consulting physician assumes the care of the patient, any subsequent services rendered will cease to be a consultation and should be billed according to the appropriate CPT/HCPCS treatment/visit codes. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP), or there must be a referral for the service from the MEDALLION PCP.

Referrals

A referral is the transfer of the total or specific care of a patient from one physician to another and does not constitute a consultation. Initial evaluation and subsequent services for a referral patient are to be billed according to CPT/HCPCS treatment/visit codes.

Dental Services

Any eligible recipient under 21 years of age can receive medically necessary dental care, such as preventive care, fillings, extractions, crowns, and prosthetics from participating dentists. The recipient can be referred directly by the physician to any dental provider participating in the Program.

End-Stage Renal Disease

Medicaid has secondary coverage to Medicare for end-stage renal disease (ESRD) treatment. Kidney transplantation when preauthorized by Medicaid and supervision of chronic hemodialysis are covered by Medicaid only when the patient is not eligible for Medicare benefits. (Medicaid will withhold payment until a determination is made concerning the patient's Medicare eligibility.)

Professional staff in the Medicare-certified ESRD facility will have responsibility for management of the treatment program and will determine the appropriate type of services needed at any time, e.g., patient hospitalization.

Dialysis centers enrolled in the Virginia Medicaid Program are responsible for submitting charges for outpatient and home dialysis services. The provider must advise the Program as to whether or not the facility charges include the physician component.

Eye Care

Ophthalmologists and other physicians skilled in treatment of diseases of the eye and its appendages may provide eye care and treatment. Eyeglasses for recipients under age 21 are covered by Virginia Medicaid; however, no more than one pair will be allowed by Virginia Medicaid within a 24-month period without a statement of medical need submitted as an attachment to the HCFA-1500 (12-90) claim form, and "Unusual Services" (individual consideration) requested (enter a "22" procedure modifier in Locator 24D of the HCFA-1500 (12-90) claim form).

The refraction which is not covered by Medicare may be billed to Medicaid. To bill Medicaid for the refraction, use CPT/HCPCS procedure code 92015 (determination of refractive state) on the HCFA-1500 (12-90) form. Place a “5” in block 24J and attach the denial from Medicare.

Contact lenses are not covered by Virginia Medicaid except as may be pre-authorized by Medicaid’s medical consultant. Authorization will be based on medical necessity and that eyeglasses cannot accomplish the optometric treatment.

Family Planning

Services and supplies for the purpose of family planning are covered regardless of age, sex, or marital status. The following Virginia Medicaid procedure codes must be used when billing for family planning visits. Virginia Medicaid reimburses for the usual and customary procedures associated with family planning services. The claims adjudication process allows for the utilization of normal claims coding guidelines but is dependant on the principal diagnosis, national family planning modifier (FP) and the Healthcare Common Procedure Coding System (which includes the Current Procedure Terminology (CPT) to relate the family planning services.

For services that are provided and there is no specific procedure code(s), the provider must use the unclassified/unspecified procedure code with the 22 and attach the necessary

information to properly process the claim. The medical documentation should include a description of the service or supply. For claims with unclassified supplies, the provider must attach the actual supply's invoice to the claim.

09007 Initial examination for family planning office visits with complete history and physical - not to exceed one in 12 months. Use the appropriate diagnosis code listed below with type of service 1, "Medical Care."

09009 Follow-up family planning office visit. Use the appropriate diagnosis code listed below with type of service 1, "Medical Care."

09011 Contraception capsules

Virginia Medicaid will reimburse its usual allowance for the insertion, removal, or removal with reinsertion of implanted contraceptive capsules regardless of any other services performed.

When a woman has contraceptive implants inserted and paid for by Medicaid, she may no longer be eligible for Medicaid when it is time to remove the implants. There is no process that would allow Medicaid reimbursement for the removal of the implants when the recipient is not Medicaid-eligible on the date of removal.

The provider must provide adequate counseling and information to recipients when they are choosing a birth control method. The counseling should include the information that the recipient must pay for the removal of the implants when removal is performed after Medicaid eligibility ends. The recipient then may decide to use a different method of contraception.

Health Maintenance Organizations must remind their network providers to provide adequate information to Medicaid recipients so that the recipients understand that the recipient must pay for the removal of the implants when removal is performed after Medicaid eligibility ends.

Virginia Medicaid will reimburse the cost of injections for contraceptive purposes. The therapeutic injection of the medication is included in the office visit when other evaluation and management medical services are rendered. If the only service rendered is the therapeutic injection of the contraceptive drug, an appropriate minimal office visit (e.g., CPT/HCPCS code 99211) may be listed in addition to the medication.

Family Planning Waiver Services (Effective Date: October 1, 2002)

Family planning services may be available for women who received a Medicaid reimbursed pregnancy related service on or after October 1, 2002, who are less than 24 months postpartum, and who have income less than or equal to 133% of the Federal Poverty Guidelines. (Women who do not meet the alien requirements for full Medicaid coverage and whose labor and delivery was paid as an emergency service under Medicaid are not eligible to participate in the family planning waiver.)

The services covered under this waiver are:

- Family planning office visit, including an annual gynecological exam, PAP testing, and sexually transmitted disease (STD) screening (at the initial family planning waiver services encounter only);
- Family Planning education and counseling (excluding any reference to abortion);
- FDA approved contraceptives;
- Over-the-counter contraceptives;
- IUD's;
- Contraceptive implants;
- Contraceptive injectables;
- Diaphragms; and
- Sterilizations (except by means of hysterectomy).

Family Planning Waiver recipients are only entitled to the services listed. If, during an office visit, a service that is not listed is provided, it will not be covered by Medicaid. Treatment of other health concerns can be provided; however, the recipient is responsible for payment for these services. The provider should refer the Family Planning Waiver recipient to a primary care provider for treatment of other conditions discovered during a family planning doctor office visit.

The Medicaid card of family planning recipients has "family planning waiver" printed on the card. Medicaid coverage for services for recipients presenting this card are limited to those listed above. Also, to receive reimbursement for services and contraceptive products, e.g., birth control pills, injectables, diaphragms, etc., one of the following diagnosis codes must accompany the procedure codes:

ICD-9 CM DIAGNOSIS CODES

CODE	DIAGNOSIS
V25.0	General Counseling and Advice
V25.01	Prescription or oral contraceptives
V25.02	Initiation of other contraceptive measures
V25.09	Other family planning advice
V25.1	Insertion of intrauterine contraceptive device
V25.2	Sterilization
V25.4	Surveillance of previously prescribed contraceptive methods
V25.40	Contraceptive surveillance unspecified
V25.41	Contraceptive pill
V25.42	Intrauterine device checking, reinsertion, removal
V25.49	Other contraceptive method
V25.9	Unspecified contraceptive management

Services to Promote Fertility

The Virginia Medicaid Program does not cover services to promote fertility. Medicaid will not pay for the medical procedure if its only goal is to make someone able to get pregnant or to get someone pregnant. If there is a disease of the reproductive system that requires treatment to maintain overall health, it will be covered. Providers must submit sufficient documentation to substantiate the medical necessity of the procedure.

To receive special consideration, providers must request individual consideration on the HCFA-1500 (12-90) by placing modifier "22" in locator 24D and attaching documentation to the claim form.

The following procedures are not covered by Virginia Medicaid for the purpose of promoting fertility:

CONTINUED ON NEXT PAGE

54900 Epididymovasostomy, anastomosis of epididymis to vas deferens, unilateral

54901 Bilateral

55400 Vasovasostomy, vasovasorrhaphy

58345 Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method) with or without hysterosalpingography

58750 Tubotubal anastomosis

58752 Tubouterine implantation

58760 Fimbrioplasty

58770 Salpingostomy (salpingoneostomy)

ICD-9 codes not covered without documentation include:

63.5 Repairs of spermatic cord and epididymis
63.53 Transplantation of spermatic cord
63.59 Other repair of spermatic cord and epididymis
63.8 Repair of vas deferens and epididymis
63.82 Reconstruction of surgically divided vas deferens
63.83 Epididymovasostomy
63.84 Removal of ligature from vas deferens
63.89 Other repair of vas deferens and epididymis
66.70 Repair of fallopian tube
66.71 Simple suture of fallopian tube
66.72 Salpingo-oophorostomy
66.73 Salpingo-salpingostomy
66.74 Salpingo-uterostomy
66.79 Other repair of fallopian tube
66.93 Implantation or replacement of prosthesis of fallopian tube
66.99 Other

Free Services

Services provided at no charge to the general public cannot be billed to Medicaid.

Hospital Visits

Effective for **admissions prior** to January 1, 2000: Payment to physicians for inpatient hospital services is limited to the number of days covered by Medicaid for the medically necessary hospital stay. Inpatient hospital (medical/surgical or psychiatric) care is limited to a maximum of 21 days for recipients 21 years of age or older. The limitation of coverage of 21 days within a 60-day period per admission for the same or similar diagnosis shall apply. Only 21 total days will be covered for the same or similar diagnosis, whether incurred in one or more hospitals during the 60-day period. Physician services to recipients under 21 years of age are not limited if the services are medically necessary and the inpatient hospitalization has been pre-authorized by Medicaid or a contractor of Medicaid.

Effective for **admissions after** January 1, 2000: Payment to physicians for inpatient hospital visits conducted in acute general hospitals will not be limited by DMAS. DMAS will be reimbursing hospitals based on AP-DRG's payment methodology for the total hospitalization rather than a daily per-diem rate. Physician services provided for psychiatric care, either to recipients hospitalized in a free-standing psychiatric hospital or as part of a psychiatric unit of a general acute care hospital, the limitation of their services is related to the number of covered days authorized by Medicaid or a contractor. Psychiatric services remain limited to 21 days for recipients age 21 or older. The limitation of 21 days within a 60-day period still remains in effect for recipients 21 years of age with same or similar diagnosis. This restriction applies whether the 21 days is within one or more hospitals within the 60-day period.

Coverage for a radical or modified radical mastectomy for treatment of disease or trauma of the breast shall be provided for a minimum of 48 hours. Coverage for a total or partial mastectomy with a lymph node dissection for treatment of disease or trauma of the breast shall be provided for a minimum of 24 hours. Additional days beyond the specified minimums for radical, modified, total, or partial mastectomies may be covered if medically justified and authorized. Nothing in this manual shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

Unauthorized inpatient services will not be covered or reimbursed by Medicaid.

Regardless of preauthorization, if the invoice reflects organ transplant, a sterilization, hysterectomy, or abortion procedure, the claim will pend for Medicaid manual review. If the required Medicaid form is not attached, the claim will be reduced or denied according to Medicaid policy.

Maternity Care

Antepartum care, delivery, and postpartum care should be billed as an all-inclusive, single unit ("global billing"), except when the antepartum care and the delivery are provided by different physicians or the recipient is enrolled as a non-resident alien. Antepartum care is not covered for these clients. (When a physician renders only antepartum care, that care must be billed as a single unit using the appropriate CPT/HCPCS code and not billed as separate office visits.)

Charges for total maternity care are to be submitted only after the final postpartum visit.

The Program recognizes that this will result in billing after the suggested 30-day timely-filing period identified in Chapter V of this manual. In cases in which total care is not provided, charges are to reflect only the services rendered. When billing for total maternity care, the date of delivery is to be used as the billing date (both "from" and "through" dates), using a one (1) in Locator 24G, "Days or Units," of the HCFA-1500 (12-90) claim form.

Psychiatric Services Under EPSDT

Medicaid provides an all-inclusive rate to freestanding inpatient psychiatric hospitals for all services rendered to Medicaid children under EPSDT. The professional component for the psychiatric care may be billed separately by the professional who is enrolled in Medicaid.

Medicaid provides a per diem rate for inpatient residential programs. The professional component for the psychiatric care and pharmacy and laboratory services are billed separately by the enrolled provider.

Hospital Preauthorization Process

The Department of Medical Assistance Services contracts the services of WVMI to provide telephonic preauthorization of all general acute care hospital admissions. For psychiatric admissions to freestanding psychiatric hospitals or a psychiatric unit of a general acute care hospital, WVMI will continue to preauthorize all admissions and lengths of stay(s). WVMI conducts the Virginia Medicaid preauthorization program from a Richmond-based office.

The preauthorization process applies to the Medicaid program only and has no effect on claims submitted under the State and Local Hospital (SLH) Program, the Non-Resident Alien Program, Medicare Title 18 claims for crossover deductibles, or recipients in Medicaid health maintenance organizations (HMOs).

The preauthorization process is conducted as a telephonic review process. Contact WVMI at the following telephone numbers:

(804) 648-3159	Richmond area
(800) 299-9864	All other areas

Planned, elective admissions must be preauthorized prior to the date of admission. Emergency or urgent admissions must be retroactively preauthorized within 24 hours or on the next business day after the admission. The health care provider calling to initiate preauthorization of the admission must provide the recipient's name, the recipient's identification number, the admitting physician's name, the primary care physician's name (if applicable), the admission diagnosis and ICD-9-CM diagnosis codes, the medical identification for hospitalization, and the plan of care. WVMI will apply InterQual Acute Care criteria to the medical information provided. If criteria are met for admission, WVMI will preauthorize the hospital stay. A preauthorization number will also be provided for billing purposes.

Once Medicaid implements a full DRG reimbursement methodology, hospitals will no longer be required to conduct concurrent review, with the exception of psychiatric inpatient stays.

For psychiatric cases, prior to the expiration of the initial assigned length of stay, if the recipient requires continued inpatient hospital care beyond the initial length of stay, the health care provider must contact the WVMI review staff to initiate the concurrent review process. The review analyst will apply criteria to the medical information provided and will assign an additional length of stay if criteria are met for continued inpatient hospitalization. Concurrent review will continue in the same manner until the recipient is discharged.

Retrospective reviews are performed when a provider is notified of a recipient's retroactive eligibility for Virginia Medicaid coverage. Prior to billing Medicaid, the health care provider must telephone the WVMI review staff to initiate a retrospective review of the medical indications and plan of care for the hospitalization in question. The review analyst

will apply InterQual Acute Care criteria to the information provided. If the hospitalization is found to meet medical necessity criteria for some or all of the stay, a preauthorization number will be assigned and the approved dates of service will be identified.

If an admission or psychiatric continued stay is determined to not meet medical necessity criteria, the provider may request reconsideration by the WVMI Utilization Management (UM) Supervisor. If the UM Supervisor agrees that medical necessity criteria are not met, the provider will be advised of the review findings via telephone and by a faxed copy of the UM Supervisor's review summary, followed by a mailed copy of the summary. If the provider continues to disagree, he or she may request reconsideration by the Medicaid physician consultant. The Medicaid physician consultant will review all available medical information, including, if possible, teleconferencing with the attending physician in an effort to obtain any additional medical information. After review, if the Medicaid physician consultant determines that medical necessity criteria are not met, he or she will advise the UM Supervisor of his or her review decision. The UM Supervisor will notify the provider via telephone and by a faxed copy of the Medicaid physician consultant's review notes, followed by a mailed copy of the review notes. The UM Supervisor will then enter the review decision, to deny or approve the authorization request, into the Medicaid Preauthorization System and a decision letter will be sent to both the provider and the recipient.

Following this two-step reconsideration process, the denial of preauthorization for services not yet rendered in an inpatient hospital setting may be appealed in writing by the Medicaid recipient within 30 days of the written notification of denial. If the preauthorization denial is for a service that has already been rendered, and the issue is whether Medicaid will reimburse the provider for the services already provided, the provider may appeal the adverse decision in writing within 30 days of the written notification of denial. Send all written appeals to:

Director
Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Medicaid and/or WVMI will perform annual desk audits of the hospital's utilization review activities. Medicaid will conduct on-site audits as necessary.

Inpatient Hospital and Early Discharge Follow-Up Visit Policy

The 1996 General Assembly passed two bills that discuss allowable insurance provisions for the length of inpatient hospital stays for maternity cases (House Bill 87 and Senate Bill 148). These bills require the Medicaid program to provide for inpatient lengths of stay in accordance with the *Guidelines for Perinatal Care* as developed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. **The language also requires payment for follow-up as recommended by the attending physician in accordance with the guidelines.**

Medicaid covers maternity inpatient hospital charges as follows. Medicaid covers the day of delivery plus an additional two days for a normal, uncomplicated vaginal delivery without requiring documentation of medical necessity. Medicaid covers the day of delivery plus an additional four days without requiring documentation of medical necessity for cesarean births. Claims for any additional days must be medically justified.

If the mother and newborn are discharged earlier than 48 hours after the day of delivery, Medicaid will cover an early discharge follow-up visit as recommended by the physician, in accordance with the guidelines. The mother and newborn must both meet the criteria for early discharge to be eligible for the early discharge follow-up visit. This early discharge visit does not affect or apply to any usual postpartum or sick/well baby care; it applies only to an early discharge. The criteria for an early discharge are in the most current edition of the *Guidelines for Perinatal Care*.

Psychiatric Services

For information regarding inpatient psychiatric services (including inpatient psychiatric services and freestanding inpatient psychiatric services) and outpatient psychiatric services, refer to the *Psychiatric Services Manual*. Payment for psychiatric services is available within Program limitations as set forth within the *Psychiatric Services Manual*.

House Calls

Payment for house calls is limited to patients who are bedridden and for whom a trip to a physician's office would be detrimental to both safety and health. CPT/HCPCS code 99056 is to be used for billing mileage. Enter "ATTACHMENT" in Locator 10D and procedure modifier "22" ("Unusual Service") in Locator 24D of the HCFA-1500 (12-90) claim form, and indicate mileage as an attachment to the HCFA-1500 (12-90) claim form.

Injections

Reimbursement for the administration of a therapeutic injection is included in the office visit when a medical service is rendered. When a therapeutic injection is the only service performed, an appropriate minimal office visit (e.g., CPT/HCPCS code 99211) may be listed in addition to the injection.

To bill for the administered drug either:

- Use the appropriate HCPCS "J" code in Locator 24D and the usual and customary charge for the injectible in Locator 24F of the HCFA-1500 (12-90) claim form; or

- Use the appropriate CPT/HCPCS code for a therapeutic injection (90782-90788) with an attachment to the HCFA-1500 (12-90) listing the substance, quantity, and cost of the drug.

Laboratory and Radiology Procedures

Payment for laboratory and radiology services will be made directly to the provider actually performing the service (i.e., physician, independent laboratory, or other participating facility). The ordering physician may bill for the handling of specimens sent to the

laboratory when billed as a single unit using CPT/HCPCS procedure code 99000. Only one specimen-handling fee is allowed per office visit. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP). Laboratory procedures performed by outside sources at no charge to the practitioner are not to be billed to Medicaid, and only a handling fee will be paid.

Providers MUST put the Clinical Laboratory Improvement Amendment (CLIA) number of the physician office laboratory (POL) performing the service in Block 19 (Reserved for Local Use) of the HCFA-1500 (12-90) claim form, as mandated by the Health Care Financing Administration.

Should the situation arise when multiple physician office laboratories are used for services for the same recipient, file a separate claim form listing the services that each laboratory performed and their applicable CLIA certificate number.

For example, if Physician Office Laboratory A performs CPT code 88150, and Physician Office Laboratory B performs CPT code 81000, and medical services are also performed on the same recipient, submit a separate claim for CPT 88150 since the CLIA number will be different than for the physician office laboratory performing CPT 81000. The medical services can be billed on either claim since the CLIA number is not applicable for medical services.

A claim will be denied if one or all of the following conditions exist:

- There is no CLIA number on the claim, and the billing is for a laboratory service.
- The CLIA number that is on the claim is invalid.
- The CLIA number is valid, but the provider is billing Medicaid for a service that is outside of the scope of the laboratory's CLIA certificate (e.g., the lab holds a Certificate of Waiver, and the provider is billing for a Physician Performed Microscopy Procedure).
- The services that are being billed were rendered outside of the effective dates of the CLIA certificate.

Providers who currently submit claims electronically should contact their service centers to have their software updated. The CLIA number must be put in the FA0 Record, Claim Service Line Record, in field number 34.0 (CLIA ID NO).

Whenever laboratory tests are performed that are generally part of a profile, the maximum payment is the appropriate automated profile rate, regardless of how the specimen is tested. This includes, but is not limited to, chemistry and hematology testing:

- The CPT/HCPCS delineates tests that are frequently done as part of a chemistry profile. When **two** or more of these tests are performed on the same specimen, in any combination, the lesser automated rate is to be billed regardless of how the specimen is tested. Medicaid requires that the services, as defined in the *CPT Manual*, be billed using the appropriate panel code and not the code for the individual components. For

codes 80049-80092, if all of the components are completed, the provider must bill using the panel code that best defines the panel.

- Whenever **four** or more components of a hemogram are performed, the appropriate hemogram CPT/HCPCS code must be used (85021-85031). CPT/HCPCS codes 85021-85030 are to be used when specimens are tested using automated equipment, and CPT/HCPCS code 85031 is to be used when specimens are tested manually.

- If fewer than four components of a hemogram are performed, bill for them using the appropriate individual CPT/HCPCS codes.

Non-Covered Services

The following laboratory and radiology services are specifically **EXCLUDED** from coverage and payment:

- Tests performed on a routine basis but not medically indicated by the patient's symptoms.

- Laboratory test professional component (CPT/HCPCS procedure modifier "26") for procedures performed in the physician's office, outpatient hospital, or in the independent laboratory. Payment for **supervision** and **interpretation** is included in the full procedure payment.

- Sensitivity studies when a culture shows no growth or urine cultures with contaminant growth (10^3 or less). Payment will only be made for the culture.

- Radiology procedure professional component (CPT/HCPCS procedure modifier "26") is used only when billing for interpretation and reporting of x-ray. The technical component (HCPCS/CPT procedure modifier "TC") is used when billing for the use of the radiology equipment.

Procedures Covered for a Pathologist or Laboratory Outside the Physician's Office

Payment for the following tests will be made only to a **pathologist**, a **hospital laboratory**, or a **participating laboratory**. Specimens for the tests listed below may also be sent to the State Laboratory:

86171	Complement fixation tests, each antigen
87116	Culture, tubercle, or other acid-fast bacilli (e.g., TB, AFB, mycobacteria); any source, isolation only
87117	Culture, tubercle, or other acid-fast bacilli (e.g., TB, AFB, mycobacteria); concentration plus isolation
87118	Culture, mycobacteria; definitive identification of each organism

87190	Sensitivity studies, antibiotic; tubercle bacillus (TB, AFB), each drug
87250	Virus identification; inoculation of embryonated eggs or small animal, includes observation and dissection

Pap Smears

Screening Pap smears shall be covered annually for females consistent with the guidelines published by the American Cancer Society.

Screening Mammography

Screening mammograms for the female recipient population aged 35 and over shall be covered consistent with the guidelines published by the American Cancer Society.

Claims for mammography services for women determined to be at high risk according to accepted medical practices that are performed at the screening frequency for high risk must be coded for unusual service (Code 22) and must include an attachment providing a brief explanation of the high-risk condition.

Screening PSA

Screening PSA (prostate specific antigen) and the related DRE (digital rectal examination) for males shall be covered, consistent with the guidelines published by the American Cancer Society.

Gynecological and Obstetric Services

Gynecological services do not require a PCP referral for recipients enrolled in the MEDALLION program. Medicaid recipients are given the same freedom of choice for these services that is currently available to the general public under private insurance and health maintenance organizations (HMOs). The Department of Medical Assistance Services implemented this change as a result of the recommendations made by a study commissioned by the Virginia General Assembly in House Joint Resolution 598.

Audiology Services

Medicaid reimburses audiologists for medically necessary services provided for diagnostic purposes to adults as long as they are physician-referred.

Physicians and audiologists must indicate the Medicaid provider number of the referring primary care physician in Block 17A (I.D. Number of Referring Physician) on the HCFA-1500 (12-90) claim form.

INTRAVENOUS SERVICES

Effective for dates of service on and after July 1, 1998, Medicaid implemented the service day rate methodology for the reimbursement of home I.V. therapy services.

DMAS convened a Task Force to research the most efficient method of ordering and reimbursing for the equipment and supplies related to the delivery of intravenous (I.V.) therapy in the home. This I.V. Therapy Task Force was comprised of durable medical equipment (DME) providers actively involved in delivering home I.V. therapy, pharmacists who provide I.V. therapy services, and Medicaid staff. The Task Force developed the policy, which is effective for claims with dates of service on and after July 1, 1998.

See "Exhibits" at the end of the chapter for a sample of the DMAS-354, Therapy Implementation Form.

Home Infusion Therapy is the intravenous administration of fluids, drugs, chemical agents, or nutritional substances to recipients in the home setting. Medicaid will reimburse for the services, supplies, and drugs only when they are determined to be:

- Medically necessary to treat a recipient's medical condition;
- In accordance with accepted medical practice; and
- Not for the convenience of the recipient or the recipient's caregiver.

The recipient must:

- Reside in either a private home or a domiciliary care facility, such as an adult care residence. Recipients in hospitals, nursing facilities, rehabilitation centers, and other institutional settings are not eligible for this service;
- Be under the care of a physician who prescribes the home infusion therapy and monitors the progress of the therapy;
- Have body sites available for I.V. catheter or needle placement or have central venous access; and
- Be capable of self-administering or have a caregiver who can be adequately trained, is capable, and is willing to administer/monitor home infusion therapy safely and efficiently following the appropriate teaching and adequate monitoring. In those cases where the recipient is incapable of administering or monitoring the prescribed therapy, and there is no adequate or trained caregiver, it may be appropriate for a home health agency to administer the therapy.

Provider Eligibility

Providers must have a valid Medicaid provider number to participate in the home I.V. therapy program. Providers eligible to participate in this program are:

- I.V. therapy providers;
- Home health agencies;
- Pharmacies; and

- DME providers.

A provider must be enrolled as a Medicaid provider and must:

- Meet any state licensing and certification requirements;
- Render infusion therapy covered services;
- Use Medicaid-established billing guidelines; and
- Accept Medicaid reimbursement as payment in full.

Therapy Coverage

Medicaid has assigned a service day rate code and reimbursement rate for each of the covered therapies:

- Hydration therapy;
- Chemotherapy;
- Pain management;
- Drug therapy; and
- Total parenteral nutrition (TPN).

Service Day Rate Definition

This payment methodology provides a fixed amount for each day of infusion therapy. The service day rate (per diem) reimburses for all services delivered in a single day. This payment methodology will be mandatory for the reimbursement of all I.V. therapy services, unless the recipient is enrolled in one of the waivered services outlined under **Special Considerations**. **Service day rates are based on an average day of service, and there will be no additional reimbursement for special or extraordinary services**. In the event of incompatible drug administration, the separate HCPCS code Z7778 has been developed to allow for the rental of a second infusion pump and the purchase of an extra administration tubing. When applicable, this code may be billed in addition to the other service day rate codes. There must be documentation to support the use of this code on the I.V. Implementation Form (DMAS-354). Proper documentation includes the need for pump administration of the medications ordered, the frequency of administration to support that they are ordered simultaneously, and an indication of incompatibility. The service day rate payment will be in two service categories: **durable medical equipment** (**DME)** and **pharmacy**.

Items in the **DME service** day rate include all supplies required to administer I.V. therapy, including but not limited to, the:

- I.V. pump/pole rental/control devices;

- Tubings, adapters, caps, needles, filters, cannulas, extension sets, and alcohol swabs; and
- I.V. start kits and central venous catheter dressing kits.

Items in the **pharmacy service** day rate include the:

- Diluent for the therapeutic agent;
- Mixing and compounding;
- Flush kits and solutions (heparin and saline); and
- Cassettes and bags/mini-bags.

Drugs used in addition to I.V. therapy, such as intramuscular and subcutaneous injections (Compazine, insulin, etc.) and subcutaneous therapies for hydration and/or pain management, are not covered under the I.V. service day rate policy. These medications and their associated DME supplies must be ordered and billed separately according to current Medicaid guidelines.

Preauthorization

The designated HCPCS codes for DME services do not require initial preauthorization, but will have a limit of three months. If the service is needed beyond the three-month-limit, it must be preauthorized. **Special Considerations:** Providers of I.V. therapy services to those recipients enrolled in special or waivered Medicaid programs must abide by all the guidelines of the program in which the recipient is enrolled.

Certificate of Medical Necessity (CMN)

The CMN must be completed for I.V. therapy DME services. The provider may fill out the CMN, but the physician must date and sign the CMN within 60 days of the begin date of service. Medicaid will not reimburse the DME provider for any DME and supplies provided prior to the date of the physician's signature when the signature is not obtained within 60 days of the first date of service. Under the item/service and HCPCS code on the CMN, list the proper code and therapy service as well as the estimated length of time needed. The I.V. Therapy Implementation Form (DMAS-354) must be completed, signed, and dated by the physician within 60 days of the therapy start date. Additionally, a copy of the doctor's order for discontinuing the therapy must be attached to each CMN and I.V. Therapy Implementation form upon completion of the therapy. The I.V. Therapy Implementation form must be initiated with the beginning of each drug and therapy service provided. The I.V. Therapy Implementation Form may be completed by the provider, but must be signed and dated by the physician.

Post-Payment Review

The Medicaid Program must ensure that only medically necessary I.V. therapy is provided to Medicaid recipients. For DME services, I.V. therapy providers **must** maintain records that contain the fully completed CMN, signed and dated by the physician; the I.V. Therapy Implementation Form (DMAS-354), with the begin and end dates for each drug/therapy

provided and signed and dated by the physician; and the order to discontinue the therapy (the official end date), signed and dated by the physician. These forms shall be furnished to Medicaid staff upon request. The absence of documentation to support I.V. therapy services may result in the retraction of moneys.

Code to Use for Incompatible Drug Therapy

In the event of incompatible drug administration, a separate HCPCS code has been developed to allow for the rental of a second infusion pump and the purchase of an extra administration tubing for each day of service. When applicable, this code may be billed in addition to the other service day rate codes. There must be documentation to support the use of this code on the I.V. Therapy Implementation Form (DMAS-354). Proper documentation includes the need for pump administration of the medications ordered, the frequency of administration to support that they are ordered simultaneously, and an indication of incompatibility. **HCPCS code Z7778** (Incompatible Drug Therapy DME) may be billed in addition to the service day rate when the documentation supports drug incompatibility.

CLIENT MEDICAL MANAGEMENT PROGRAM

As described in Chapter I of this manual, the State may designate certain recipients to be restricted to specific physicians and pharmacies. When this occurs, it is noted on the Medicaid recipient's ID card. A Medicaid-enrolled physician who is not the designated primary provider may provide and be paid for outpatient services to these recipients only:

- In a medical emergency situation in which a delay in the treatment may cause death or result in lasting injury or harm to the recipient.
- On written referral from the primary health care provider using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians.
- For other services covered by Medicaid which are excluded from the Client Medical Management Program requirements.

See “Exhibits” in Chapter I for details.

EMERGENCY ROOM SERVICES UNDER CLIENT MEDICAL MANAGEMENT

General Information

Reimbursement for emergency room services for Client Medical Management (CMM) recipients will be automatically paid if the Admitting (presenting signs/symptoms) diagnosis appears on Diagnoses to Be Paid at Emergency Rate by ICD-9-CM CM Code (see “exhibits” at the end of this chapter for the list.)

Client Medical Management (CMM) recipients must have a written primary care provider (PCP) referral in order for non-emergency services provided in the emergency room to be reimbursed at the all-inclusive rate of $20. The PCP must use the Practitioner Referral Form, DMAS-70. Payment will be denied without a referral unless there is a life-threatening emergency. Non-emergency services provided without a PCP referral become

non-covered services, and the recipient is responsible for the full cost of the emergency room visit. When billing for emergency room services, the attending physician bills evaluation and management codes with CPT codes 99281-99285 and enters "1" in Block 24I. When the PCP has referred the recipient to the emergency room, place the PCP's identification number in Block 17A on the HCFA-1500 (12-90) and attach the Practitioner Referral Form, DMAS-70. Write "attachment" in Block 10D. **PCP referral IS required for reimbursement to CONSULTING physicians who treat a CMM client in the emergency room setting.**

The following requirements will be applied either individually or in combination to determine the payment for medical services provided in the outpatient hospital emergency room setting. Flexibility with individual patient status and conditions is taken into consideration in the use of these guidelines.

The recipient's age and the time of admission to the emergency room do not determine the emergency status. The conditions relating to the emergency visit will determine the emergency status. The requirement of non-scheduled medical treatment for the stabilization of an injury or condition will support an emergency.

Direct physical attendance by a physician is required in emergency situations. The visit will not be considered an emergency unless the physician's entries into the record include his or her signature, the diagnosis, and documentation that he or she examined the patient. The attendance of a physician assistant does not substitute for the attendance of a physician.

Telephone or standing orders, or both, do not support emergency treatment.

GENERAL INFORMATION:

The Department of Medical Assistance Services uses the prudent layperson standard as defined in the Balanced Budget Act of 1997 (BBA). Accordingly, emergency services is defined as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part." The threat to life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services. The requirement of non-scheduled medical treatment for the stabilization of an injury or condition will support an emergency.

Direct physical attendance by a physician is required in an "emergency" situation. If the physician has not made entries other than his or her signature and diagnosis on the medical record and no documentation is noted that he or she examined the recipient, the visit will not be considered an emergency. The attendance of a physician assistant does not substitute for the attendance of a physician.

Telephone or standing orders, or both, do not support emergency treatment.

Emergency room claims that are reviewed by the staff at DMAS will be done in a manner that reflects the prudent lay person requirements. Hospitals and physicians should insure that the documentation to support the medical necessity for the emergency visit is complete and legible.

Emergency Situations:

- Initial treatment following a recent injury. "Recent" is defined as having occurred less than 48 hours prior to the visit
- An injury sustained over 48 hours prior to the visit and the symptoms have deteriorated to the point of requiring medical treatment for stabilization.

  Note: Minor injuries requiring only simple first aid that can be done in the home such as cleansing and bandaging an abrasion, are not considered emergencies. A secondary diagnosis such as Diabetes Mellitus may support the emergent need if substantiated.

- Initial treatment for medical/surgical emergencies, including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered "life-threatening."
- Visit in which the recipient's condition requires immediate hospital admission or transfer to another facility for further treatment or visit.
- Motor Vehicle Accident (MVA) within 48 hours.
- Physical abuse (suspected or confirmed) within 48 hours.
- Acute vital sign changes including, but not limited to, the following:

  Adult:

  Temperature of 103° F or higher
  Pulse rate below 40/minute
  Pulse rate above 140/minute
  Respiratory rate below 10/minute
  Respiratory rate above 30/ minute
  Systolic blood pressure below 90mm Hg
  Systolic blood pressure above 200mm Hg
  Diastolic blood pressure below 40mm Hg
  Diastolic blood pressure above 120mm Hg

Pediatric**:**

Temperature of 102° F or higher
Pulse rate above 180/minute for patients under 3 months of age
Pulse rate above 160/minute in patients over 3 months of age
Pulse rate below 70/minute in patients under 3 months of age
Pulse rate below 50/minute in patients over 3 months of age
Respiratory rate above 40/minute in patients under 1 year of age
Respiratory rate above 30/minute in patients over 1 year of age
Systolic blood pressure below 65mm Hg in patients 6 months and under

Systolic blood pressure below 80mm Hg in patients 6-12 months of age
Systolic blood pressure above 100mm Hg in patients 0-7 years of age
Systolic blood pressure above 120mm Hg in patients 7-10 years of age
Systolic blood pressure above 140mm Hg in patients 10 years and older

Diastolic blood pressure above 90mm Hg in all pediatric patients
Diastolic blood pressure below 40mm Hg in all pediatric patients

- Use of IV fluids for hydration purposes.

Non-Emergency Conditions (unless the criteria described below have been met):

Depression/Anxiety: Documentation must clearly indicate that the recipient is an immediate danger to self or others.

Otitis Media – not an emergency unless one or more of the following is noted:

- The tympanic membrane is ruptured.
- There is drainage from the ear(s).
- A fever is documented while in the emergency room:

  Children: Temperature of 102°F or above rectally
  Adult: Temperature of 103°F or above orally

- The recipient is age 2 or under and is crying inconsolably.
- The physician's examination documents the presence of acute otitis media, and there is no access to a physician's office due to being after office hours or on a holiday or a weekend.

Seizures – not an emergency unless:

- The condition was previously undiagnosed, and the visit is immediately following or during a seizure.
- A secondary disorder/diagnosis exists (i.e., hypoglycemia, infection)
- The recipient is 12 years of age or younger.
- Accompanied to the ER by a law enforcement officer and the condition was unknown.
- The recipient is in status epilepticus.

- The recipient is in an epileptic state aggravated by alcohol or drug ingestion

Non-Emergency Situations:

- Non-compliance with previously ordered medications or treatments resulting in continued symptoms of the same condition.
- Refusal to comply with currently ordered procedures or treatments, such as drawing blood for lab work.
- The recipient had previously been in the same or different emergency room or in a physician's office for the same condition without worsening signs or symptoms of the condition.
- Scheduled visits to the emergency room for procedures, examinations, or medication administration. Examples include, but are not limited to, cast changes, suture removal, dressing changes, follow-up examinations, and consultations for a second opinion.
- Visits made to receive a "tetanus" injection in the absence of other emergency conditions.
- Visits made to obtain medications in the absence of other emergency conditions.
- The conditions or symptoms relating to the visit have been experienced longer than 48 hours or are of a chronic nature, and no emergency medical treatment was provided to stabilize the condition.
- Medical Clearance/Screenings for Psychological or Temporary Detention Order admissions.

Emergency Room Services (Except for Recipients in the Client Medical Management Program) [Effective Date: July 1, 1991]

Reimbursement for emergency room services for Medicaid recipients (not enrolled under the Client Medical Management Program) will be automatically paid if the principal diagnosis appears on Diagnoses to Be Paid at Emergency Rate by ICD-9 CM Code (see "Exhibits" at the end of this chapter for this list). Claims for emergency services with the principal diagnosis on Diagnoses to Pend for Review By ICD-9 CM Code will pend for review of the necessary documentation supporting the need for emergency services. (See "Exhibits" at the end of this chapter for this list.) Effective with emergency room claims with date of service on or after June 1, 2001, the Admitting (presenting signs/symptoms) diagnosis will be utilized to determine the pay or pend status of the claim. All claims that are reviewed by the staff at DMAS will be done in a manner that reflects the prudent lay person requirements.

Effective with claims with dates of service on or after June 1, 2001, all emergency room claims will either be paid for emergency services or pend for DMAS review to determine the emergency situation warranting care. DMAS will pay an all-inclusive fee of $30.00 to the hospital for those claims found not in compliance for emergency room services. All-inclusive is defined as all emergency room and ancillary service charges claimed in association with the emergency room visit, with the exception of laboratory services. Laboratory services will continue to be reimbursed under the existing system of rates. Claims identified as emergencies will also be reimbursed under existing rates.

The ordering and interpretation of appropriate diagnostic tests are considered part of the payment to the physician in the emergency department. A professional component for these services may not be billed separately by a physician in the emergency department, and no separate payment will be made to the physician in the emergency department for a professional component. The professional component will be reimbursed only to those providers who interpret a test and sign and issue the final report.

Follow-Up Care Post ER Visit

Any follow-up outpatient or office consultations for CMM clients require a referral from the primary care physician. Place the PCP's Medicaid identification number in Locator 17A on the HCFA-1500 (12-90). Attach the written referral form and mark Locator 10D "attachment."

DURABLE MEDICAL EQUIPMENT

MEDALLION Coverage

If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP). If a specialist orders services for the recipient, the MEDALLION PCP must have made the referral to the specialist. The specialist must maintain documentation of coordination of services with the MEDALLION PCP.

Coverage of Apnea Monitors

As a part of the Quality Care Assurance routine program evaluation of durable medical equipment (DME) and in response to concerns and questions that had been raised, the Department reconvened the Apnea Monitor Task Force to evaluate the appropriateness of the criteria for initial use, continuance of use, discontinuation, and other issues related to the coverage of apnea monitors. The Task Force consisted of physicians representing all regions of the state, respiratory therapists, durable medical equipment providers, and DMAS staff, including medical consultants and other health professionals. In addition, an extensive literature search for standards of practice was initiated. The following policy is a result of the work of this Task Force and became effective for claims with dates of service on and after January 1, 1996.

Diagnoses Which Automatically Meet Criteria and Identified-High Risk Conditions

Apnea monitor usage for individuals with the following diagnoses or identified high-risk conditions will be approved for payment if the diagnosis/condition is supported with a completed Certificate of Medical Necessity (CMN) with appropriate supporting and verifiable documentation:

- Apparent life-threatening episode(s), i.e., Gastro Esophageal Reflux, severe; apnea; seizures; cardiac arrhythmias;
- Apnea of Prematurity;
- Bronchopulmonary Dysplasia/Chronic Lung Disease of Infancy with oxygen dependency;
- Respiratory Control Disorder such as: Congenital Hypoventilation, Obstructive Sleep Apnea, Central Apnea, Obstructive Airway Disease;
- Infant or child with Tracheostomy;
- Infant of drug-dependent mother, symptomatic for apnea;
- Sibling of SIDS (payment will be made for six months from birth or up to one month beyond age of sibling at time of death); and
- Congenital Anomalies, at risk of airway obstruction.

If the recipient does not meet the above criteria, the request will be reviewed in accordance with the following criteria.

Criteria for Home Monitoring

The instrument recommended for home use must monitor both cardiac and respiratory status. Apnea mattresses or displacement pads are not appropriate. The recipient may use either the recording or non-recording monitor. One or more of the following will be used for selection of patient home monitoring (initial and ongoing continued use), with appropriate supporting individual documentation:

- Observed or recorded episode of prolonged apnea with no identifiable and/or treatable cause or an inadequate response to treatment;
- Documented apnea associated with bradycardia, cyanosis, or pallor;
- History of apnea described by parent or caretaker and documented in the medical records; or
- Evidence of abnormal respiratory control.

Guidelines for Discontinuation of Monitor Reimbursement

Initial approval for payment will be for a period up to four (4) months (120 days). If continued use is indicated by medical necessity, supporting and verifiable medical documentation must be submitted to the Department of Medical Assistance Services) for review and preauthorization.

Reimbursement for apnea monitors will be discontinued when a clinical evaluation (including neurological, developmental, and physical examinations) shows that the problems or the initial reasons behind the decision to monitor have been resolved or stabilized:

- The patient has been free of events requiring stimulation or resuscitation for 2-4 months; **or**
- The patient has experienced significant stressors such as respiratory illness or immunizations without apnea; **or**
- There is normalization of a previously abnormal respiratory pattern or no prolonged apnea episodes for 2-4 months.

Pneumograms/Downloads, Polysomnagrams, and Multi-Channel Sleep Studies

Definitions:

> **Pneumogram** is a 2-channel study of breathing and heart rate, including EKG signal and chest wall movement. A download serves the same purpose as a pneumogram if the recipient is monitored on a recording apnea monitor.
>
> **Multi-channel sleep study** contains three or more signal sources that may include: cardiac EKG signal, respiratory air flow, body position, oximetry, esophageal pH, and quantitative end tidal CO_2.
>
> **Polysomnagram** includes cardiac EKG signal, respiratory chest wall movement, respiratory abdominal wall movement, respiratory airflow, body position, oximetry, esophageal pH, and quantitative end tidal CO_2, EEGx2, EOG x2, and EMG, attended by a technologist.

It was determined that reimbursement for these studies should be made based on the number of channels in the study. Criteria for determining the number of appropriate channels to be studied would be determined by the attending or ordering physician. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP).

The certificate of medical necessity documentation must specify the number of signals and what signals are to be done and whether or not interpretation is to be done. Documentation must include the download documentation and a wave form analysis. A summary report must be maintained at the provider's location.

If a recording monitor is being used and downloaded, a pneumogram is not needed to document the continuing need for the monitor. This information will be obtained from the download summary report. If a recipient with a recording monitor needs a pneumogram, the DME provider must submit a request for prior authorization.

Billing Procedures

There are three codes that the DME provider can use when billing for these studies. HCPCS code Z5905 will be used for a two-channel pneumogram or download without interpretation. HCPCS code Z5906 will be used for a two-channel pneumogram or download that includes interpretation. HCPCS code Z5909 will be used for a multi-channel sleep study or

polysomnagram with or without interpretation. The technical component (scoring) must be included in these three codes.

HCPCS Codes	Description	Billing Unit	Authorization	Limits	Comments
Z5905	2-Channel Pneumogram/Download without interpretation	Each	No	1 per month	See Below.
Z5906	2-Channel Pneumogram/Download with interpretation	Each	No	1 per month	See Below.
Z5909	Multi-channel sleep study or polysomnagram with or without interpretation	Channel or Signal	Yes	I.C.	See Below.
If a recording monitor is being used and downloaded, a pneumogram is not needed to document the continuing need for the monitor. If a recipient with a recording monitor needs a pneumogram, the DME provider must submit a request for prior authorization.					

Documentation Requirements for Reimbursement of Apnea Monitors and Diagnostic Studies

For the initial 120 days which do not require preauthorization, there must be a Certificate of Medical Necessity (CMN) stating the recipient's diagnosis that indicates the need for a monitor or a description of the recipient's condition.

The following documentation is required for the continued use of an apnea monitor over 120 days:

1. A CMN and documentation outlining what the recipient has experienced related to apnea in the previous 120 days of monitoring, including:

    a) The dates and number of occurrences of observed apnea;

    b) An interpretation of any related diagnostic tests;

        For example: an upper GI series for GE reflux; pneumograms, or downloads for recording apnea monitors, that are interpreted and indicated that the child had clinically significant apnea during the first 120 days and/or the condition is resolving;

    c) Download reports with clinical interpretation from recording monitors, (the physician is encouraged to order a pneumogram for those children on non-recording apnea monitors in order to get a clear picture of what the child is experiencing);

d) Adequate and verifiable documentation on the CMN of the oxygen flow rate for those recipients who continue on oxygen, if applicable; and

e) Adequate and verifiable documentation of the month of death of any sibling who expired due to Sudden Infant Death Syndrome if the child was placed on the monitor for this reason.

2. A comprehensive history and record of physical examination, with appropriate work-up including specific pulmonary studies as indicated (i.e., sleep airway studies and fluoroscopy, transcutaneous oxygen, pulse oximetry, recording monitor download analysis, and carbon dioxide monitor or pneumogram studies).

The provider must submit a clinical description to DMAS staff of what happened during the first 120 days and why the monitor continues to be needed. This description is comprised of a history and physical, interpreted downloads or pneumograms that show a test history, indication of special considerations (need for oxygen, need to receive immunization stressors, need to reach significant age for a sibling of SIDS), and a physician's assessment of what happened during the first 120 days of monitoring to warrant continued use. It is the responsibility of the recipient's physician to interpret the data. It is the responsibility of the DME provider to obtain the interpretation from the physician and submit it to Medicaid.

Documentation for discontinuation of apnea monitor reimbursement will consist of a clinical evaluation (including neurological, developmental, and physical examinations) which shows that the problems or the initial reasons behind the decision to monitor have been resolved or stabilized.

Documentation for pneumograms, polysomnagrams, and multi-channel sleep studies must specify the number of signals and what signals are to be done and whether or not interpretation is to be done. Documentation must include the download documentation and a wave form analysis.

The DME provider must maintain all documentation (CMN, summary reports, delivery tickets, billing) on file at the location that is serving the recipient. Documentation must be maintained on file for five years.

Rental Versus Purchase of an Apnea Monitor Criteria

Medicaid does not require preauthorization for the initial 120 days. If the physician determines that the recipient will need the apnea monitor longer than 120 days but less than eight months, the DME provider must obtain authorization for continued rental from Medicaid. To obtain authorization, the DME provider must submit supporting documentation for the additional time requested. If the physician determines that the recipient will need the apnea monitor eight months or longer, the DME provider must request purchase of the apnea monitor with supporting documentation at the initiation of service or time of determination of long-term usage. At the time of purchase, the DME vendor is required to provide a new monitor with a full manufacturer's warranty.

Non-Compliant Behavior

The provider shall document the non-compliant use of the apnea monitor in the recipient's file. Non-compliant use of the apnea monitor by the recipient or the recipient's caregiver is a refusal to provide care necessary for the child's health and creates a substantial risk of death for the child. The provider shall report non-compliant behavior to the attending physician or health care professional. There shall be compliance with Section 63.1-248.3 of the *Code of Virginia*. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP). The Department of Medical Assistance Services shall continue to reimburse for the monitor while reasonable efforts to insure compliant behavior are taken.

Information About Service Agreements for Purchased Apnea Monitors

HCPCS code Z5908 has been developed to cover the service and maintenance of purchased apnea monitors. HCPCS code Z5908 requires preauthorization. The service maintenance agreement will allow for trouble-shooting and download visits (18 visits per six months). Downloading can be done during a trouble-shooting visit. The vendor can utilize these 18 visits for any combination of trouble-shooting or download visits.

Providers must agree to send the purchased monitor to the manufacturer for necessary servicing. The cost for servicing, shipping, and handling will be covered in HCPCS code Z5907, and preauthorization is required. A copy of the manufacturer's invoice for servicing must be attached to the invoice. These invoices will pend for manual review before reimbursement is made.

The service maintenance agreement does not include repairs. All repairs must be requested under the established HCPCS code for repairs.

Service Agreement for Purchased Apnea Monitors

The service maintenance agreement requires preauthorization by Medicaid in order for the provider to be reimbursed. Once service maintenance is authorized, the provider may bill using the HCPCS codes in the DME listing. The following services must be included as part of the service maintenance agreement:

- The provider agrees to employ or contract with staff who will be available to make timely necessary home visits related to the use of the apnea monitor. The DME vendor must assure that the staff being sent into the home are qualified to render the necessary services.

- The provider agrees to perform routine maintenance of the apnea monitor in the home, replacing rib belts, lead wires, and electrodes (disposable or reusable) associated with this routine maintenance. Supplies that must be provided under this agreement are listed in the table below. If the recipient requires additional supplies that are medically justified, these supplies can be requested on a DMAS-351 (see " Exhibits" at the end of this chapter for a sample of this form) preauthorization request with attached medical justification that documents the need for these additional supplies.

- The cost for trouble-shooting and download visits will be included in the service maintenance agreement fee (18 visits per six months). Downloading can be done during a trouble-shooting visit. These 18 visits can be utilized by the vendor for any combination of trouble-shooting or download visits.

- The provider agrees to provide a back-up apnea monitor throughout the period of apnea monitor repairs or services. The DME vendor may bill Medicaid for a rental apnea monitor for up to one month during routine repairs/services using the established HCPCS code. The rental must only be for the actual time the monitor is out of the home being serviced by the manufacturer.

- The cost of parts which would constitute a repair may be billed separately as a repair using the established HCPCS codes for repairs.

- The provider agrees to send the apnea monitor for necessary servicing by the manufacturer. The cost for servicing, shipping, and handling will be covered in a separate HCPCS code. The provider must attach a copy of the CMN and manufacturer's invoice to the claim in order for the claim to be paid. Medicaid will pend claims for this HCPCS code for manual adjudication.

HCPCS CODE	DESCRIPTION	BILLING UNIT	AUTHORIZATION	LIMITS	COMMENTS
Z5908	Service Maintenance Agreement for a Patient-Owned Apnea Monitor	Each	yes	2/12 Months	
SUPPLIES REQUIRED TO BE PROVIDED WITHIN THE SERVICE MAINTENANCE AGREEMENT 12 ELECTRODES DISPOSABLE OR 2 REUSABLE ELECTRODES 2 LEAD WIRES 2 RIB BELTS					

Enteral Nutritional Supplements

Nutritional supplements may only be provided by enrolled durable medical equipment (DME) vendors and be reimbursed based on HCPCS codes that define categories of supplements. A fixed fee amount is established for the categories.

Coverage of enteral nutrition which does not include a legend drug is limited to when the supplement is the sole source form of nutrition (except for individuals authorized through the Technology-Assisted or AIDS Waiver or through EPSDT where the supplement must be the primary source of nutrition), is administered orally or through a nasogastric or gastrostomy tube, and is necessary to treat a medical condition. Coverage of oral administration does not include the provision of routine infant formulae.

Sole source means that the individual is unable to handle (swallow or absorb) any other form of oral nutrition. **Primary source** means that nutritional supplements are medically indicated for the treatment of the recipient's condition if the recipient is unable to tolerate oral nutrients. The patient may either be unable to take any oral nutrition or the oral intake that can be tolerated is inadequate to maintain life. The focus must be the maintenance of weight and strength commensurate with the patient's condition.

The physician's order (the Certificate of Medical Necessity [CMN]) must specify either a brand name of the supplement being ordered or the category of enteral nutrition which must be provided. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP). If a specialist orders services for the recipient, the MEDALLION PCP must have made the referral to the specialist. The specialist must maintain documentation of coordination of services with the MEDALLION PCP.

If a physician orders a specific brand of supplement, the DME provider must supply the brand prescribed. **The physician's order must include the daily caloric intake ordered and the route of administration for the supplement.** The physician's order (the CMN) is valid for a maximum of six months regardless of the recipient's age. A face-to-face nutritional assessment completed by trained clinicians (i.e., physician, registered nurse, registered dietitian) must be completed as required documentation of enteral nutrition for both the initial order and every six months. An optional nutritional assessment form, DMAS-115 (Nutritional Evaluation Form), that contains all of the required assessment elements is provided to DME providers; however, providers may use any format, provided that all the elements are addressed. **Home health visits for the sole purpose of performing a nutritional assessment for recipients whose conditions are stable and chronic in nature will not be covered under the home health program.**

The nutritional assessment **must** include the following elements:

1. Height (or length for pediatric recipients);
2. Weight (if unobtainable, may provide mid-arm circumference and triceps skinfold test data). For initial assessments, indicate the patient weight loss over time;
3. Formula tolerance (e.g., the patient is experiencing diarrhea, vomiting, constipation). This element is only required if the patient is already receiving a supplement;
4. Tube or stoma site assessment, as applicable;
5. Indication of whether the supplement is the primary or sole source of nutrition;
6. Route of administration; and
7. Section F must include the daily caloric order and the number of calories per package/can/etc.

The DME provider must assure that there is a physician's order and nutritional assessment, completed in accordance with Medicaid policy, on file for any Medicaid recipient for whom enteral nutrition is provided. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP).

BLOOD GLUCOSE MONITORS AND TEST STRIPS

Coverage Criteria for Blood Glucose Monitors for Medicaid Recipients

Medicaid will reimburse for blood glucose monitors and associated supplies for patients under the DME program when the following criteria are met:

- The patient has a condition that requires adjustment of insulin dosage based on at least daily blood glucose findings **or** the patient has clinically demonstrated unstable glucose readings and must report frequent findings to a physician for adjustment of medications; and

- There must be written verification that the patient and/or caregiver have participated in diabetic training (diet, medication, monitoring, etc.) and that the patient and/or caregiver have demonstrated the ability to appropriately use the prescribed blood glucose monitor.

The Department of Medical Assistance Services will reimburse for blood glucose monitors and test strips for pregnant women suffering from diabetes for whom the physician determines nutritional counseling alone will not be sufficient to assure a positive pregnancy outcome.

At the time the physician completes the Maternity Risk Screen (DMAS-16) and determines that the woman is at risk due to her diabetes, the physician must indicate on the risk screen a referral for nutritional counseling and authorize the use of a blood glucose monitor. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP), or there must be a referral for the service from the MEDALLION PCP. If nutritional counseling by a Registered Dietitian (RD) is not available, counseling may be provided by the physician or a nutritionist. Medicaid will only reimburse for nutritional counseling provided by a RD or an individual with a masters degree in Nutrition or Clinical Dietetics. This Maternity Risk Screen assessment form is the authorization which can then be presented to a Medicaid-enrolled durable medical equipment (DME) provider for delivery of the blood glucose monitor and test strips. Medicaid preauthorization using the DMAS-351 is not required.

The CPT/HCPCS code for blood glucose monitors is E0607, and the CPT/HCPCS code for the test strips is A4253.

DME providers must keep a copy of the Maternity Risk Screen in their files as authorization for blood glucose monitor reimbursement.

COUNSELING, HIV TESTING, AND TREATMENT FOR PREGNANT WOMEN

The *Code of Virginia* §54.1-2403.01 requires providers to counsel pregnant women on the importance of HIV testing during pregnancy and treatment if the testing results are positive.

As a routine component of prenatal care, every licensed practitioner who renders prenatal care, regardless of the site of such practice, must advise each patient of the value of testing for Human Immunodeficiency Virus (HIV) infection and request that she consent to such

testing. Practitioners must also counsel all pregnant women with HIV-positive test results about the dangers to the fetus and the advisability of receiving treatment in accordance with the current Centers for Disease Control recommendations for HIV-positive pregnant women. All pregnant women shall have the right to refuse consent to testing for HIV infection and any recommended treatment. Documentation of such refusal must be maintained in the patient's medical record.

The HIV/AIDS epidemic is increasing in women of childbearing age and spreading beyond previously defined risk groups and geographic areas. This increase has been paralleled by a similar increase in children. The Health Care Financing Administration estimates that a minimum of 90% of children infected with HIV are Medicaid beneficiaries.

Clinical trials were conducted under the National Institutes of Health on the use of AZT (zidovudine) to prevent perinatal transmission of AIDS. The clinical trials [AIDS Clinical Trial Group 076 (ACTG 076)] demonstrated that participants who received AZT therapy had a 66% reduction in transmission of HIV from the mother to her newborn. The results of this clinical trial were significant because perinatal transmission accounts for most cases of HIV infection among children.

As the primary caretakers of this population, both the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) strongly believe that the answer lies in an aggressive HIV education and counseling initiative. They have issued a joint statement stating "clear medical benefits of knowing the HIV status of pregnant women and newborns have been documented. Treatments are currently available to significantly reduce the HIV transmission from mother to infant (zidovudine/AZT). This finding represents the most important medical breakthrough in this area in recent years. In addition, the lives of the infants, not protected by the AZT treatments in utero, may be prolonged by initiating medical care within the first months of life. For newborns whose mother's HIV status was not determined during pregnancy, the infant's health care provider should educate the parent(s) concerning HIV testing and recommend HIV testing for the newborn."

The combined strategy of HIV counseling for all pregnant women and voluntary HIV testing is already proving effective in several communities. Voluntary testing means that after a woman receives appropriate counseling from her health care provider, she is able to make an informed decision about having a test for HIV. Studies show that when her health care provider talks with a pregnant woman about the test and what it means for her and her baby, most women choose to be tested and then to be treated as their doctor recommends. For example, in one inner-city hospital, 96% of women chose to be tested after receiving HIV counseling.

Printed copies of the "U.S. Public Health Service Recommendations for HIV Counseling and Voluntary Testing for Pregnant Women" and "Recommendations of the U.S. Public Health Service Task Force on the Use of Zidovudine to Reduce Perinatal Transmission of Human Immunodeficiency Virus" (MMWR 1994; 44[RR-11]) which have more information about AZT treatment during pregnancy are available from the CDC National AIDS Clearinghouse (CDC NAC). Printed copies may be ordered by calling the CDC National AIDS Hotline (1-800-342-AIDS). The Hotline can also provide information about any

AIDS-related issue. The guidelines are also available electronically through CDC NAC on-line bulletin board as well as through other HIV/AIDS bulletin boards, including the Internet.

For specific information regarding the 076 Clinical Trial or any other HIV/AIDS clinical trial, call the AIDS Clinical Trial Information Service (ACTIS) at 1-800-TRIALS A. For information regarding treatment and care of HIV infection and AIDS, including the use of AZT in pregnant women, call the HIV/AIDS Treatment Service (ACTIS) at 1-800-448-0440.

BILLING PROCEDURES FOR NEWBORN SCREENING TEST KITS

Virginia Medicaid has assigned a specific procedure code, Z9549, to be used when billing for the Newborn Screening Test Kit obtained from the Division of Consolidated Laboratories. The physician may bill for the medical care rendered, the kit, and the handling fee.

Use Code Z9549 to bill for these kits for which the charge to Virginia Medicaid is the amount that the Consolidated Laboratories charges for the test kit.

BABYCARE SERVICES

To ensure a positive pregnancy outcome and infant health, high-risk pregnant women and high-risk infants up to age two often need a combination of medical and non-medical services. BabyCare services help meet these needs. These services are defined as preventive/curative services including group patient education, nutritional services, homemaker services, substance abuse services, and high-risk maternal care coordination services, in addition to maternity care. The physician is a primary link in identifying high-risk recipients. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP). An authorization for high-risk BabyCare services entitles the pregnant woman, or high-risk infant, to a formal case management process including prenatal services.

The inclusion of BabyCare services for high-risk pregnant women and high-risk infants up to age two in the Medicaid Program is to directly address and correct two major barriers that negatively affect pregnancy outcomes: (1) fragmentation and lack of coordination in service delivery, and (2) lack of patient knowledge of and ability to successfully access the health care system. Since many of these women have a difficult time getting through the service network, BabyCare coordinators should assure that patients actually receive the health care services necessary for improved pregnancy outcomes.

The major goals of BabyCare services are to:

1. Reduce infant mortality and morbidity by improving pregnancy outcomes;

2. Ensure access to comprehensive preventive and therapeutic services by pregnant women and their infants; and

3. Assist pregnant women and infants under age two in meeting other priority needs that affect their well-being and that of their families.

Risk Screens

A risk screen must be completed prior to a referral for BabyCare services. The risk screen is a systematic review of the pregnant woman or infant's medical/obstetrical/developmental conditions as well as his or her lifestyle and environment. Its purpose is to identify potential or existing problems and plan for care directed at preventing or improving those problems.

If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP). The screen is completed by a physician, nurse practitioner, or certified nurse midwife to identify those patients in need of BabyCare services in addition to maternity or pediatric care. (See "**Exhibits**" at the end of the chapter for a sample of the forms.) Following the completion of the form, the provider must sign the form including his or her title.

A copy of the Maternity Risk Screen should be attached to the claim. The following Virginia Medicaid procedure codes must be used when billing for the risk screen (effective August 1, 1992):

Z9010 Infant risk screen

Z9001 Maternity risk screen

One hundred percent of both Medicaid-eligible pregnant women and infants up to age two should receive a risk screen to identify patients at risk for a poor outcome.

Some recipients may need more than one screen completed as risk conditions may develop at different times throughout the pregnancy and infancy period.

BabyCare Referral Process

A copy of any risk screen which indicates that the recipient is at risk should be given to the maternal and infant care coordinator (MICC). Depending on the risks and referrals identified, the MICC will then start the enrollment process for the program. If the recipient is not identified as high-risk, the provider will still be reimbursed for completing the screen.

A recipient may be referred to any or all services on the Risk Screen which will enable a positive outcome.

If the recipient requires case management services due to an identified risk, the provider should refer the recipient to care coordination.

The nutritional services referral is appropriate for a pregnant woman who has nutritional needs which require extensive counseling. This service is provided in addition to routine diet information the recipient receives through the Women, Infants, and Children (WIC) program. Medicaid will reimburse the provider agency for a nutritional assessment and two

(2) follow-up sessions. These services must be provided by a Registered Dietitian (R.D.) or an individual with a masters degree in nutrition.

If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP).

A pregnant or postpartum woman may be referred for homemaker services if the physician determines that bedrest is required before or after delivery. Homemaker services are provided to maintain the normal household routine while the pregnant or postpartum woman is on bedrest.

A pregnant or postpartum woman may be referred for substance abuse services if the physician determines that the pregnant or postpartum woman requires these services.

Childbirth, parenting, and smoking cessation classes are included in the patient education program. The recipient may be referred to the class which best meets her needs. Recipients are not required to be high-risk to attend a patient education class.

The BabyCare services provider cannot receive payment without a copy of the risk screen authorizing specific services. Call the HELPLINE at 1-800-552-8627 (786-6273 in Richmond) for the names and addresses of BabyCare service providers in the local community.

Care Coordination Services

Care coordination as provided by a qualified maternal and infant care coordinator (MICC) is a formal case management process with a primary focus on the organization of services and resources to respond to the health care needs of high-risk pregnant women and infants. The process consists of the successful completion of the following activities:

1. Risk Screen - The care coordinator obtains a risk screen from the physician, nurse practitioner, or certified nurse midwife provider with a referral for specific services;

2. Assessment - Determines the recipient's service needs which include psychosocial, nutrition, medical, and educational factors;

3. Service Planning - Develops an individualized description of the services and resources needed to meet the service needs of the recipient and helps to access those resources;

4. Coordination and Referral - Assists the recipient in arranging for the appropriate services and ensures the continuity of care;

5. Follow-Up and Monitoring - Assesses ongoing progress and ensures that services are delivered; and

6. Education and Counseling - Guides the recipient and develops a supportive relationship that promotes the service plan.

Care Coordination Billing Codes

Use the following codes to bill for Maternal and Infant Care Coordination:

Z9104	Completion of maternal and infant needs assessment
Z9105	Monthly Care Coordination - Maternal
Z9106	Monthly Care Coordination - Infant
A0160	Mileage for home visits (for codes Z9104-Z9106)

Maternal and Infant Care Coordinator (MICC)

A maternal and infant care coordinator is a registered nurse or social worker employed by a qualified service provider who provides care coordination services to eligible recipients. The R.N. must be licensed in Virginia and should have a minimum of one year of experience in community health nursing and experience in working with pregnant women. The social worker must have a M.S.W. or B.S.W. degree and a minimum of one year of experience in a health care setting working with pregnant women and their families. The maternal and infant care coordinator is a health care professional who, in cooperation with the physician, assists recipients in accessing the health care and social system in order to promote physical and emotional health.

BabyCare Forms

The Maternal Risk Screen (DMAS-16), the Maternal Care Coordination Record (DMAS-50), and the Pregnancy Outcome Report (DMAS-53) forms, as well as the Infant Care Forms, must be used for recipient enrollment into the BabyCare Program.

The following forms are used for the BabyCare Program.

Maternity Risk Screen	(DMAS-16) Rev. 8/93
Infant Risk Screen	(DMAS-17) Rev. 3/92
Maternal Care Coordination Record	(DMAS-50) Rev. 8/93
Infant Care Coordination Record	(DMAS-51) Rev. 3/92
Care Coordination Service Plan	(DMAS-52) Rev. 3/92
Pregnancy Outcome Report	(DMAS-53) Rev. 8/93
Infant Outcome Report	(DMAS-54) Rev. 3/92
Recipient's Letter of Agreement	(DMAS-55) Rev. 3/92

See Chapter V for instructions for ordering these forms.

Prenatal Care Services

Patient Education (Group)

This service includes six sessions of group education for pregnant women and their partners in a planned, organized teaching environment in courses such as Preparation for Childbirth

or Parenthood, and Smoking Cessation. A recipient may receive educational services alone without enrollment in care coordination.

Homemaker Services

Homemaker services include those services necessary to maintain the household routine for pregnant or postpartum women when bedrest is ordered by a physician. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP). These services include, but are not limited to, light housekeeping, child care, laundry, shopping, and meal preparation. The physician must make a homemaker referral on the risk screen and services must be provided by a Medicaid-enrolled BabyCare provider. Duties may be performed by a companion, homemaker, nursing assistant, or home health aide.

Note: See "Physician's Role in Home Health Services" in this chapter. The physician may wish to consider the availability of home health services for his or her pregnant and postpartum patients.

Nutritional Services

Nutritional services include nutritional assessment of dietary habits, nutritional counseling, and counseling follow-up. All pregnant women are expected to receive basic nutrition information through their medical care providers or the WIC Program. Additional nutritional education and special diet information are included when appropriate.

The initial orientation and periodic follow-up will include instructions concerning basic nutrition during pregnancy, referral and linkage with WIC, ongoing focus on gestationally appropriate weight gain, dietary intake, and special diet information.

Nutritional services must be provided by a registered dietitian (R.D.) or person with a masters degree in nutrition or clinical dietetics. Both require experience in public health, maternal and child nutrition, or clinical dietetics.

The criteria for referral are pre-pregnancy underweight, inadequate or excessive weight gain, teenager 18 years of age or younger, poor diet, or obstetrical medical conditions requiring diet modification, such as multiple gestation, delayed uterine growth, and anemia.

Substance Abuse Therapy Services for Pregnant and Postpartum Women

Medicaid provides coverage for the following substance abuse services for pregnant and post partum women.

<u>Substance Abuse Residential Treatment</u>

This service provides for intensive intervention in residential facilities, other than inpatient facilities, for pregnant and postpartum women with serious substance abuse problems for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle. For billing purposes, one unit is equal to one day. This service is billed using code Z8994 in Locator 24D of the HCFA-1500 (12-90)

claim form. This service is limited to up to 330 days of consecutive treatment, once per lifetime, not to exceed 60 days postpartum.

Substance Abuse Day Treatment

This service provides for intensive intervention in a central location lasting two or more consecutive hours per day, which may be scheduled multiple times per week, for pregnant and postpartum women with serious substance abuse problems for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle. For billing purposes, one unit is equal to 1-3.99 hours; two units is equal to 4 to 7 hours, and three units is equal to more than 7 hours. This service is billed using code Z8997 in Locator 24D of the HCFA-1500 (12-90) claim form. This service is limited to a maximum of 440 units in a twelve-month consecutive period, once in a lifetime, not to exceed 60 days postpartum.

Providers of BabyCare Services

BabyCare services may be provided by the following: physicians, local departments of social services, community health centers, local departments of health, rural health clinics, home health agencies, personal care agencies, and hospital clinics with signed BabyCare service agreements with the Department of Medical Assistance Services. The substance abuse services for pregnant and postpartum women are provided by participating providers.

MATERNITY RISK SCREEN INSTRUCTIONS

PURPOSE:

1. To identify high-risk maternity patients eligible for care coordination. (See "**Exhibits**" at the end of the chapter for a sample of the form.)

2. To identify maternity patients at risk for poor pregnancy outcome who need additional prenatal care services (homemaker, patient education and nutritional counseling).

PROVIDER: The risk screen is performed by the physician, nurse practitioner or certified nurse midwife. The patient may be referred during pregnancy to the care coordinator for any of the risk conditions which are listed on the Risk Screen. The risk conditions on the form should not be altered by the provider. Suggestions or information regarding the recipient or referrals may be written in the instructions section at the bottom of the form. The provider must sign the form including his or her title.

REFERRALS: If care coordination is deemed not necessary, document other services the recipient will receive, e.g., routine maternity care.

DEFINITION:

Underweight: less than 90% of Standard Weight.

Inadequate weight gain: less than 2 1/4 lbs. per month in the second and third trimesters or less than 9 lbs. by 20 weeks.

Excessive weight gain: more than 7 lbs. per month for two months if normal or overweight.

Height Without Shoes	90% Standard Weight	Height Without Shoes	90% Standard Weight
4'8"	91	5'5"	119
4'9"	94	5'6"	122
4'10"	96	5'7"	126
4'11"	99	5'8"	130
5'0"	102	5'9"	133
5'1"	104	5'10"	137
5'2"	106	5'11"	140
5'3"	111	6'0"	144
5'4"	115		

DISTRIBUTION OF COPIES: One (1) copy must accompany each referral. The original must be retained by the physician in patient's medical chart.

INFANT RISK SCREEN INSTRUCTIONS

PURPOSE: To identify high-risk infants who need care coordination services. (See "**Exhibits**" at the end of the chapter for a sample of the form.)

PROVIDER: The risk conditions on the form should not be altered by the provider. Suggestions or information regarding the recipient or referrals may be written in the instructions section at the bottom of the form. The provider must sign the form including his or her title.

REFERRALS: If care coordination is deemed not necessary, document the other services the recipient will receive, e.g., routine pediatric care.

DISTRIBUTION OF COPIES: Send one (1) copy to the care coordinator. Retain the original in the patient's medical chart.

MEDICAL EQUIPMENT AND SUPPLIES

Expendable medical supplies normally used in the physician's office, such as gauze, dressings, syringes, and culture plates, are included in the Medicaid Program's reimbursement for the office visit or test performed. Only the actual cost of special expendable medical supplies, such as an ace bandage or a surgical tray, can be billed to Medicaid.

DME and supplies are a covered service available to the entire Medicaid population. In addition, the Medicaid may cover DME services when any of the following are met:

- The recipient is under age 21 and the item or supply could be covered under the Virginia *State Plan for Medical Assistance* (the *State Plan*) through the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT);
- The recipient is enrolled in the Technology Assisted Waiver Program; or
- The recipient is enrolled in the AIDS Waiver Program.

All medically necessary medical equipment and supplies under the *State Plan* may be covered only if they are necessary to carry out a treatment prescribed by a physician. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP). Unusual amounts, types, and duration of usage must be authorized by Medicaid in accordance with published policies and procedures. When determined to be cost-effective by Medicaid, payment may be made for rental of the equipment in lieu of purchase. (Virginia *State Plan for Medical Assistance,* Supplement 1 to Attachment 3.1-A&B, 7-D, 1.a.)

Durable medical equipment (DME) and supplies that are medically necessary, physician-ordered on the Certificate of Medical Necessity (DMAS-352), and for use in the home environment are reimbursable for the general Medicaid population. The non-covered DME and supplies are outlined in the *State Plan for Medical Assistance* and the *Durable Medical Equipment and Supplies Manual*.

DME and supplies for home use do not require that the recipient meet the home health criteria by being classified as homebound; therefore, DME and supplies may be obtained through an enrolled DME provider who must request preauthorization when required.

Procedure Codes for Medical Supplies and Equipment Used in the Practitioner's Office

In the course of treatment in a practitioner's office, it may be necessary to use supplies and/or equipment beyond those routinely included in the office visit. The applicable CPT/HCPCS code may be used when billing for a specific supply item.

The following procedure codes may be used in the absence of a CPT/HCPCS code when billing for the specific medical supplies:

	Item	Procedure Code
	Catheter Tray	00010
	Ace Bandage	00011
	Surgical tray	00012
	Sling	00013
	Splint	00014
	Rib Belt	00015
	Cane	00016
	Crutches	00017
	Cervical Collar	00018
	Lumbosacral Support	00019
*	Unlisted Supplies	00020

* Note: When using procedure code 00020, Unlisted Supplies, an explanation provided as an attachment to the HCFA-1500 (12-90) claim form must describe the item and its cost. The manufacturer's invoice should also be attached.

MATERNITY AND NEWBORN INPATIENT CARE

Normal vaginal deliveries with a length of stay less than or equal to three days from the date of admission do not require preauthorization. Cesarean section deliveries with a length of stay less than or equal to five days from the date of admission also do not require preauthorization. It is important to remember that these length of stays are calculated from the date of admission and not the date of delivery. The Medicaid contractor, WVMI, must preauthorize maternity stays which do not fall within these parameters. This preauthorization must be on file with Medicaid prior to billing for the stay. The hospital must obtain all preauthorizations.

Newborns who are in the normal nursery with a length of stay less than or equal to five days from the infant's date of birth also do not require preauthorization. Preauthorization will be required for the entire newborn stay if the infant is in any other nursery setting for any part of the stay. It is important to remember that for newborns, the infant may only be in the normal nursery, and the length of stay is calculated from the date of birth and may not exceed five days. WVMI must preauthorize newborn stays which do not fall within these parameters. This preauthorization must be on file with Medicaid prior to billing for the stay.

These preauthorization requirements have no impact on the mandated maternal lengths of stay under the Virginia Medicaid inpatient hospital and early discharge follow-up visit policy.

Nurse Practitioners

Virginia Medicaid reimburses family and pediatric nurse practitioners including laboratory and immunization procedures. The reimbursement rate is the same as that for other enrolled providers performing laboratory and immunization procedures.

ROUTINE NEWBORN CARE

The initial newborn care should be billed under the mother's identification number as long as she remains in the hospital. This includes a physical examination of the baby, the initiation of diagnostic and treatment programs, and the preparation of hospital records. Physician's care provided to the infant after the mother leaves the hospital should be billed under the infant's own identification number. (See Chapter III for information on billing for twins.)

Newborn Circumcision

Circumcision of a newborn male (CPT/HCPCS procedure codes 54150 and 54160) is covered when billed under the newborn's own identification number. This procedure is sex-specific and cannot be paid if billed under the mother's identification number.

NURSING FACILITY VISITS

Nursing facility visits are covered as medical conditions require. However, subsequent nursing facility services are limited to one per month unless the medical necessity for more frequent visits is explained as an attachment to the HCFA-1500 (12-90) claim form and is indicated through the use of the procedure modifier "22" ("Unusual Services") in Locator 24D.

PHYSICAL THERAPY

Medically necessary physical therapy treatments are covered. The physician may only charge for physical therapy provided in his or her office by the physician or by a licensed physical therapist under his or her supervision. When only physical therapy is provided, an office visit charge may not be submitted to the Program.

PROSTHETIC DEVICES

A. Prosthetic services shall mean the replacement of missing arms, legs, eyes, and breasts and the provision of an internal (implant) body part. Nothing in this regulation shall be construed to refer to orthotic services or devices or organ transplantation services.

B. Artificial arms and legs, and their necessary supportive attachments, implants, and breasts are provided when prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional licenses as defined by state law. This service, when provided by an authorized vendor, must be medically necessary, and preauthorized for the minimum applicable component necessary for the activities of daily living.

C. Eye prostheses are provided when eyeballs are missing regardless of the age of the recipient or the cause of the loss of the eyeball. Eye prostheses are provided regardless of the function of the eye. Preauthorization is not required, but post-payment review is conducted.

To obtain the required preauthorization for coverage, the prosthetist will ask the prescribing practitioner to complete a DMAS Certificate of Need (DMAS-4001). The prosthetist will then submit the Certificate of Need, a copy of the physician's prescription, and a completed Prosthetic Device Preauthorization Request to:

Director of Medical Support
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

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SUBSTANCE ABUSE THERAPY SERVICES

All hospital admissions at the acute care level, associated with or determined to have developed as a result of substance abuse are covered services. Examples of these are acute gastritis, hematemesis, seizures, and coma as a result of the abuse of alcohol.

Also covered is the treatment of chronic problems attributable to substance abuse. Examples of these are peptic ulcer, pancreatitis, cirrhosis, polyneuropathy, cardiomyopathy, and delirium tremens caused by abuse of alcohol.

The Program is not funded to cover treatment modalities employed to "rehabilitate" patients afflicted by substance abuse. These "rehabilitative" services are specified in 42 CFR 440.130(d) and are not included in the Virginia *State Plan*. Medicaid provides coverage for substance abuse services for pregnant and postpartum women. Refer to the "BabyCare" section in this chapter for information regarding these services.

SURGERY

Covered surgical procedures which are medically necessary are compensable.

Abortion (Elective)

Induced (elective) abortions will be paid for by the Department of Medical Assistance Services only upon the physician's certification that in his or her professional medical judgment the life or health of the mother would be substantially endangered if the fetus were carried to term and that such judgment shall be exercised in light of all factors (physical, emotional, psychological, familial, and the woman's age) relevant to the well-being of the patient. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP).

Note: Reimbursement is available for the treatment of incomplete, missed, or septic abortions.

If, in the physician's professional judgment, the woman's life or health would be endangered by carrying the fetus to term, an abortion certification form, DMAS-3006 (See "Exhibits" at the end of the chapter for a sample of the form), must accompany each claim for an induced (elective) abortion. Note that, if a woman's life would be endangered by carrying the fetus to term, the attending physician must so certify. However, if this is not the case, but her health would nonetheless be substantially endangered, the attending physician must certify that fact. These different certifications are necessary to comply with federal reporting requirements which differentiate the degrees of medical necessity for the abortion and which enable matching federal funds to be used.

The originating physician is required to supply a copy of the proper certification to other billing providers. Any claim submitted using the following procedure codes without the appropriate physician certification or required documentation will be pended. If the appropriate information is not attached, the claim will be denied.

- Abortions Performed During a Period of Retroactive Eligibility - Reimbursement is available for those abortions performed during periods of retroactive eligibility if the physician will certify in writing on the DMAS-3006 form that, in his or her professional judgment, the life or health of the mother would have been endangered if the fetus had been carried to term. The certification must also contain the name and address of the patient.

- Abortion Procedure Codes - CPT/HCPCS procedure codes 59840, 59841, 59850, 59851, 59852, 59855, 59856, or 59857 must be used as appropriate in submitting all physician and hospital claims for induced (elective) abortions.

Regardless of the preauthorization for the hospitalization, if the invoice reflects an abortion procedure, the claim will pend for Medicaid manual review. If the forms are not properly completed, or not attached to the bill, the claim will be denied or reduced according to Medicaid policy.

Assistant Surgeon

Assistant surgeon fees are covered when services of an assistant surgeon are considered medically necessary due to the complexity of the procedure. The assistant surgeon must be an enrolled provider and is to bill the procedure using the appropriate procedure code and procedure modifier "80", "81", or "82" in Locator 24D of the HCFA-1500 (12-90) claim form.

Breast Reconstruction/Prosthesis following Mastectomy and Breast Reduction

With prior authorization, breast reconstruction surgery and prosthesis may be covered following the medically necessary complete or partial removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorized, for all medically necessary indications. Such procedures shall be considered non-cosmetic.

Breast reconstruction or enhancements for cosmetic reasons shall not be covered. Cosmetic reasons shall be defined as those which are not medically indicated or are intended solely to preserve, restore, confer, or enhance aesthetic appearance of the breast.

Biopsy

Biopsy procedures performed concurrently with major surgical procedures are included in the payment for the major procedure.

Cosmetic Surgery

Cosmetic surgery is not covered when provided solely for the purpose of improving appearance. The exclusion of cosmetic surgery does not apply to congenital deformities or to deformities due to recent injury. When surgery also restores or improves a physiological function, it is not considered cosmetic surgery. Written prior authorization must be obtained from the Program. All requests for prior authorization should be directed in writing to:

Director of Medical Support
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

A copy of the authorization letter must be attached to the claim form to obtain payment.

Elective Surgery

Elective surgery, as defined by the Virginia Medical Assistance Program, is surgery that is not medically necessary to restore or materially improve a body function. This includes surgery for conditions such as morbid obesity, virginal breast hypertrophy, and procedures that might be considered cosmetic. Written prior authorization must be obtained from the Program. All requests for prior authorization should be directed in writing to:

Director of Medical Support
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

A copy of the authorization letter must be attached to the claim form to obtain payment.

Transplant Surgery

Transplant services which are covered when medically necessary without regard to age and are not experimental or investigational are: kidney and corneal transplants (effective September 7, 1989); heart, lung, and liver transplants (effective July 1, 2000); coverage of bone marrow transplants for individuals over 21 years of age is allowed for a diagnosis of lymphoma or breast cancer (effective July 1, 1997), leukemia (effective July 1, 1999), or myeloma (effective July 1, 2000); under EPSDT, any other medically necessary transplant procedures that are not experimental or investigational are limited to persons under the age of 21 (effective July 19, 1993).

The treating facility and transplant staff must be recognized by Virginia Medicaid as being capable of providing high-quality care in the performance of the requested transplant.

All transplants except for corneal transplants require preauthorization (including kidney, liver, heart, lung, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational) by Medicaid Medical Support.

Transplant services for kidneys require prior written authorization (see Appendix A – Definitions, “Preauthorization Request”), and the patient must be considered by Virginia Medicaid as acceptable for coverage. All requests for prior authorization must be made in writing to:

Director of Medical Support
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If approved, a copy of the authorization letter must be attached to obtain payment.

All requests for prior authorization, except cornea transplants, should be directed in writing to:

Director of Medical Support
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

A copy of the authorization letter must be attached to the claim form to obtain payment.

Inpatient hospitalization related to transplantation requires preauthorization at the time of admission and concurrently for length of stay.

Cornea transplants do not require preauthorization of the procedure, but inpatient hospitalization related to such transplants requires preauthorization for admission, and concurrently, for the length of stay.

For all transplants, the patient must be considered acceptable for coverage and treatment.

Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined not to be experimental or investigational is a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by Medicaid or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement covers:

- Procurement costs;
- All hospital costs from admission to discharge for the transplant procedure; and
- Total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, etc.

The flat fee reimbursement does not include pre- and post-hospitalization for the transplant procedure or pre-transplant evaluation. If the actual charges are lower than the fee, Medicaid will reimburse actual charges. Send claims directly to:

Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Reimbursement for approved transplant procedures that are performed out-of-state is made in the same manner as reimbursement for transplant procedures performed in Virginia. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate.

Additionally, specific criteria issued by Medicaid concerning patient and facility selections must be followed for all transplant services.

Transplantation of the kidney is a surgical treatment whereby a diseased kidney is replaced by a healthy organ. Preauthorization is required. The following patient selection criteria apply for the consideration of all approvals for the coverage and reimbursement for kidney transplantation.

1. Current medical therapy has failed, and the patient has failed to respond to appropriate conservative management;

2. The patient does not have other systemic disease including, but not limited to, the following:

    a) Reversible renal conditions;
    b) Major extra-renal complications (malignancy, systemic disease, cerebral cardio-arterial disease);
    c) Active infection;
    d) Severe malnutrition; or
    e) Pancytopenia.

3. The patient is not both in an irreversible terminal state and on a life support system;

4. Adequate supervision will be provided to assure there will be strict adherence to the medical regimen which is required;

5. The kidney transplant is likely to prolong life and restore a range of physical and social function suited to activities of daily living;

6. A facility with appropriate expertise has evaluated the patient and has indicated the willingness to undertake the procedure; and

7. The patient does not have multiple uncorrectable severe major system congenital anomalies.

Failure to meet these criteria will result in the denial of the preauthorization and coverage for the requested kidney transplant procedures.

For a medical facility to qualify as an approved Virginia Medicaid provider for performing kidney transplants, the following conditions must be met:

1. The facility has available expertise in immunology, infectious disease, pathology, pharmacology, and anesthesiology;

2. The kidney transplantation program staff has extensive experience and expertise in the medical and surgical treatment of renal disease;

3. Transplant surgeons on the staff have been trained in the kidney transplantation technique at an institution with a well-established kidney transplantation program;

4. The transplantation program has adequate services to provide specialized psychosocial and social support for patients and families;

5. Adequate blood bank support services are present and available;

6. Satisfactory arrangements exist for donor procurement services;

7. The institution is committed to a program of at least 25 kidney transplantations a year;

8. The center has a consistent, equitable, and practical protocol for the selection of patients (at a minimum, the Medicaid Patient Selection Criteria must be met and adhered to);

9. The center has the capacity and commitment to conduct a systematic evaluation of outcome and cost;

10. In addition to hospital administration and medical staff endorsement, hospital staff support also exists for such a program;

11. The hospital has an active, ongoing renal dialysis service;

12. The hospital has access to staff with extensive skills in tissue typing, immunological, and immunosuppressive techniques; and

13. Initial approval as a kidney transplantation center requires performance of 25 kidney transplantations within the most recent 12 months, with a one-year survival rate of at least 90%. Centers that fail to meet this requirement during the first year will be given a one-year conditional approval. Failure to meet the volume requirement following the conditional approval will result in the loss of approval.

Transplantation of the cornea is a surgical treatment whereby a diseased cornea is replaced by a healthy organ. While preauthorization is not required, the following patient selection criteria apply for the consideration of all approvals for reimbursement for cornea transplantation:

1. Current medical therapy has failed and will not prevent progressive disability;

2. The patient is suffering from one of the following conditions:

   a) Post-cataract surgical decompensation,
   b) Corneal dystrophy,
   c) Post-traumatic scarring,
   d) Keratoconus, or

e) Aphakia Bullous Keratopathy;

3. Adequate supervision will be provided to assure there will be strict adherence by the patient to the long-term medical regimen which is required;

4. The corneal transplantation is likely to restore a range of physical and social function suited to activities of daily living;

5. The patient is not both in an irreversible terminal state and on a life support system;

6. The patient does not have untreatable cancer, bacterial, fungal, or viral infection; and

7. The patient does not have the following eye conditions:

   a) Trichiasis,
   b) Abnormal lid brush and/or function,
   c) Tear film deficiency,
   d) Raised transocular pressure,
   e) Intensive inflammation, and
   f) Extensive neo-vascularization.

The facility selection criteria for cornea transplantation are:

1. The facility has available expertise in immunology, infectious disease, pathology, pharmacology, and anesthesiology;

2. The cornea transplantation program staff has extensive experience and expertise in the medical and surgical treatment of eye disease;

3. The transplant surgeons on the staff have been trained in the cornea transplantation technique at an institution with a well-established cornea transplantation program;

4. The transplantation program has adequate services to provide social support for patients and families;

5. Satisfactory arrangements exist for donor procurement services;

6. The institution is committed to a program of eye surgery;

7. The center has a consistent, equitable, and practical protocol for the selection of patients (at a minimum, the Medicaid Patient Selection Criteria listed above must be met and adhered to);

8. The center has the capacity and commitment to conduct a systematic evaluation of outcome and cost;

9. In addition to hospital administration and medical staff endorsement, hospital staff support also exists for such a program;

10. Initial approval as a cornea transplantation center requires performance of corneal transplant surgery, with a one-year graft survival rate of at least 75%. Centers that fail to meet this requirement during the first year will be given a one-year conditional approval. Failure to meet this requirement following the conditional approval will result in the loss of approval.

The patient selection criteria for the provision of liver, heart, allogeneic, autologous bone marrow transplantation, and any other medical necessary transplantation procedures that are determined not to be experimental or investigational are:

A. General

The following general conditions apply to these services:

1. Coverage shall not be provided for procedures that are provided on an investigational or experimental basis;

2. There must be no effective alternative medical or surgical therapies available with outcomes that are at least comparable;

3. The transplant procedure and application of the procedure in the treatment of the specific condition for which it is proposed have been clearly demonstrated to be medically effective and not experimental or investigational; and

4. Prior authorization by Medicaid is required. The prior authorization request must contain the information and documentation required by Medicaid.

The following patient selection criteria apply for the consideration of authorization, coverage, and reimbursement:

1. The patient must be under 21 years of age at the time of the surgery; and

2. The patient selection criteria of the transplant center where the surgery is to be performed shall be used in determining whether the patient is appropriate for selection for the procedure. Transplant procedures will be preauthorized only if the selection of the patient adheres to the transplant center's patient selection criteria, based upon review by Medicaid of the information submitted by the transplant team or center.

    a) The recipient's medical condition shall be reviewed by the transplant team or program according to the transplant facility's selection criteria for that procedure, and the recipient shall be determined by the team to be an appropriate transplant candidate. Patient selection criteria used by the transplant center shall include, but not necessarily be limited to, the following:

1. Current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management;

2. The patient is not in an irreversible terminal state; and

3. The transplant is likely to prolong life and restore a range of physical and social function suited to the activities of daily living.

Facility selection criteria for liver, heart, allogeneic and autologous bone transplantation, and any other medically necessary transplantation procedures that are determined to not be experimental or investigational are:

The following general conditions apply:

1. Procedures may be performed out of state only when the authorized transplant cannot be performed in Virginia because the service is not available or, due to capacity limitations, the transplant cannot be performed in the necessary time period.

2. Criteria applicable to transplantation services and centers in Virginia also apply to out-of-state transplant services and facilities.

To qualify for coverage, the facility must meet, but not necessarily be limited to, the following criteria:

1. The transplant program staff has demonstrated expertise and experience in the medical and surgical treatment of the specific transplant procedure;

2. The transplant surgeons have been trained in the specific transplant techniques at an institution with a well-established transplant program for the specific procedure;

3. The facility has expertise in immunology, infectious disease, pathology, pharmacology, and anesthesiology;

4. The facility has staff or access to staff with expertise in tissue typing, immunological, and immunosuppressive techniques;

5. Adequate blood bank support services are available;

6. Adequate arrangements exist for donor procurement services;

7. Current full membership in the United Network for Organ Sharing for the facilities where solid organ transplants are performed;

8. Membership in a recognized bone marrow accrediting or registry program for bone marrow transplantation programs;

9. The transplant facility or center can demonstrate satisfactory transplantation outcomes for the procedure being considered;

10. Transplant volume at the facility is consistent with maintaining quality services; and

11. The transplant center will provide adequate psychosocial and social support services for the transplant recipient and family.

Criteria for high-dose chemotherapy and bone marrow/stem cell transplantation (coverage for persons over 21 years of age) are:

The following general conditions apply to these services:

1. This must be the most effective medical therapy available yielding outcomes that are at least comparable to other therapies.

2. The transplant procedure and application of the procedure in the treatment of the specific condition for which it is proposed have been clearly demonstrated to be medically effective.

3. Prior authorization by Medicaid is required. The prior authorization request must contain the information and documentation as required by Medicaid.

The following patient selection criteria apply for the consideration of authorization for coverage and reimbursement for individuals who have been diagnosed with lymphoma or breast cancer and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone marrow/stem cell transplant:

1. The patient selection criteria of the transplant center where the treatment is to be performed shall be used in determining whether the patient is appropriate for selection for the procedure. Transplant procedures will be preauthorized only if the selection of the patient adheres to the transplant center's patient selection criteria, based upon review by Medicaid of the information submitted by the transplant team or center.

2. The recipient's medical condition shall be reviewed by the transplant team or program according to the transplant facility's patient selection criteria for that procedure, and the recipient shall be determined by the team to be an appropriate transplant candidate. Patient selection criteria used by the transplant center shall include, but not necessarily be limited to, the following:

a. The patient is not in an irreversible terminal state (as demonstrated in the facility's patient selection criteria), and

b. The transplant is likely to prolong life and restore a range of physical and social function suited to the activities of daily living.

The facility selection criteria for high-dose chemotherapy and bone marrow/stem cell transplantation for individuals diagnosed with lymphoma or breast cancer are:

A. The following conditions shall apply:

1. Procedures may be performed out of state only when the authorized transplant cannot be performed in Virginia because the service is not available, or due to capacity limitations, the transplant cannot be performed in the necessary time period.

2. Criteria applicable to transplantation services and centers in Virginia also apply to out-of-state transplant services and facilities.

B. To qualify for coverage, the facility must meet, but not necessarily be limited to, the following criteria:

1. The transplant program staff has demonstrated expertise and experience in the medical treatment of the specific transplant procedure;

2. The transplant physicians have been trained in the specific transplant technique at an institution with a well-established transplant program for the specific procedure;

3. The facility has expertise in immunology, infectious disease, pathology, pharmacology, and anesthesiology;

4. The facility has staff or access to staff with expertise in tissue typing, immunological, and immunosuppressive techniques;

5. Adequate blood bank support services are available;

6. Adequate arrangements exist for donor procurement services;

7. Membership in a recognized bone marrow accrediting or registry program for bone marrow transplantation programs;

8. The transplant facility or center can demonstrate satisfactory transplantation outcomes for the procedure being considered;

9. Transplant volume at the facility is consistent with maintaining quality services; and

10. The transplant center will provide adequate psychosocial and social support services for the transplant recipient and family.

These services, excluding cornea transplants, require written prior authorization (see Appendix A - Definitions, "Preauthorization Request"), and the patient must be considered acceptable for coverage. Direct all requests for prior authorization in writing to:

Director of Medical Support
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

A copy of the authorization letter must be attached to the claim form to obtain payment.

Bone Marrow Transplants and Clarification of the Reimbursement for Transplants

Medicaid covers Bone Marrow Transplants to all eligible individuals who have a diagnosis of lymphoma or breast cancer effective for dates of services on and after July 1, 1997. The transplant procedure must be preauthorized by the Medical Support Unit of DMAS, and hospitals must have the admission and length of stay for inpatient services approved by WVMI.

Reimbursement for transplants is a contractual fee that covers procurement costs, all hospital costs from admission to discharge for the transplant procedure, and total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, anesthesiologists, etc. The contractual fee does not include pre- and post-hospitalization for the transplant procedure, nor does it include pre-transplant evaluation.

To ensure that reimbursement is correctly calculated, hospitals must include all physicians' fees on the claim. Reimbursement shall be based on the contractual fee amount or the actual charges, should they be less than the contractual fee. Send the claims for the transplant procedure directly to:

Department of Medical Assistance Services
Attention: Payment Processing Unit
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Endoscopy

Payment for endoscopy procedures performed concurrently with a related major surgical procedure is included in the payment for the major procedure.

Experimental Surgery

Surgery considered experimental in nature is not covered.

Hysterectomies

According to federal regulations, hysterectomy is not a sterilization procedure. Hysterectomies performed solely for the purpose of rendering an individual incapable of reproducing are not covered by Medicaid. Payment may be made for hysterectomies as follows:

- Medically Necessary - A medically necessary hysterectomy may be covered only when the person securing the authorization to perform the hysterectomy has informed the individual or her representative, if applicable, orally and in writing before the surgery is performed that the hysterectomy will render the individual permanently incapable of reproducing, and the individual or her representative has signed a written Acknowledgment of Receipt of Hysterectomy Information Form, DMAS-3005. (See "**Exhibits**" at the end if the chapter for a sample of the form). If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP). If a specialist orders services for the recipient, the MEDALLION PCP must have made the referral to the specialist. The specialist must maintain documentation of coordination of services with the MEDALLION PCP. The Physician Statement must be completed and signed by the physician, and in this situation, Block A must be marked.

  When a hysterectomy is performed as a consequence of abdominal exploratory surgery or biopsy, the Acknowledgment of Receipt of Hysterectomy Information Form (DMAS-3005) is also required. Therefore, it is advisable to inform the patient or her representative prior to the exploratory surgery or biopsy. Again, Block A of the Physician Statement must be completed.

- Emergency - When a hysterectomy is performed on an emergency basis because of life-threatening circumstances, Block B of the Physician Statement must be marked and a description of the nature of the emergency must be included. The completed Physician Statement must be attached to each claim form related to the hysterectomy (e.g., surgeon, hospital, anesthesiologist). The patient does not have to sign this form. An example of this situation would be when the patient is admitted to the hospital through the emergency room for immediate medical care and the patient is unable to understand and respond to information pertaining to the acknowledgment of receipt of hysterectomy information due to the emergency nature of the admission.

- Sterility - If the patient is sterile prior to the hysterectomy, Block C of the Physician Statement must be marked and a statement regarding the cause of the sterility must be included. The completed Physician Statement must be attached to each invoice related to the hysterectomy (e.g., surgeon, hospital, anesthesiologist). The patient does not have to sign the form. (For example, this form would be used when the sterility was post-menopausal or the result of a previous surgical procedure.)

- A copy of the form DMAS-3005 must be attached to each provider's invoice for a hysterectomy procedure if Medicaid is to consider the claim for payment. Failure to provide the appropriate acknowledgment or certification will result in the denial of the claim. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP).

Regardless of the preauthorization for the hospitalization, if the invoice reflects a hysterectomy, the claim will pend for Medicaid manual review. If the forms are not properly completed, or not attached to the bill, the claim will be denied or reduced according to Medicaid policy. The originating physician is required to supply other billing providers with a copy of the DMAS-3005.

- CPT/HCPCS Hysterectomy Procedure Codes

  51597 Pelvic exenteration, complete, for vesical, prostatic, or urethral malignancy, with removal of bladder and ureteral transplantations, with or without hysterectomy and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof;

  51925 Closure of vesicouterine fistula with hysterectomy;

  56308 Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy);

  58150 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);

  58152 with colpo-urethrocystopexy (Marshall-Marchetti-Krantz, Burch);

  58180 Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s);

  58200 Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s);

  58210 Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s);

  58240 Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof;

  58260 Vaginal hysterectomy;

  58262 Vaginal hysterectomy with removal of tube(s), and/or ovary(s);

  58263 Vaginal hysterectomy with removal of tube(s), and/or ovary(s), with repair of enterocele;

58267 Vaginal hysterectomy with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type, with or without endoscopic control);

58270 Vaginal hysterectomy with repair of enterocele;

58275 Vaginal hysterectomy, with total or partial colpectomy;

58280 Vaginal hysterectomy, with total or partial colpectomy; with repair of enterocele;

58285 Vaginal hysterectomy, radical; (Schauta type operation);

58951 Resection of ovarian malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy;

59135 Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy requiring total hysterectomy;

59525 Subtotal or total hysterectomy after cesarean delivery;

- Hysterectomies Performed During a Period of Retroactive Eligibility - Reimbursement is available for hysterectomies performed during periods of retroactive eligibility if the physician will certify on the DMAS-3005 that one of the following conditions was met:

    1) He or she informed the recipient before the operation that the procedure would make her sterile. In this case, the patient and the physician must sign the DMAS-3005; or

    2) The recipient met one of the exceptions provided in the Physician Statement Section of the DMAS-3005. In this case, no recipient signature is required.

Multiple Procedures

Multiple surgical procedures may require manual review during the payment process. The major procedure is given maximum payment with related procedures reimbursed at 50 percent of the maximum payment for the related procedure. Surgical procedures incidental to the primary procedure are not covered. For example: an appendectomy incidental to gall bladder surgery is not covered.

Preoperative and Postoperative Care

Routine, uncomplicated preoperative and postoperative medical care related to the primary surgery are considered included as part of the surgical reimbursement allowance and therefore may not be billed separately.

Pelvic Examination Under Anesthesia

The following CPT/HCPCS codes are related surgical procedures that include pelvic examination under anesthesia:

Laparoscopy	56300-56309 56343-56344
Abortion	59812-59857
Tubal ligation	58600-58720
Cervical cauterization	57500, 58120, 58145
Hysteroscopy	56350-56356
Other procedures	57000-57335 57320-57460 58260-58301 58800, 58820, 58823, 59870, 59871

When any of these procedures is performed and billed for, CPT/HCPCS code 57410 is not appropriate for separate concurrent billing.

NOTE: CPT/HCPCS procedure codes 56301-56303, 58983, 58600-58720, and 56307 also require Sterilization Consent Forms.

Mandatory Outpatient Surgical and Diagnostic Procedures

The Department of Medical Assistance Services will not reimburse the hospital and/or practitioner for the outpatient surgical or diagnostic procedures listed in Appendix B when performed on an inpatient basis unless the procedure meets one of the exceptions to this policy. This policy applies to all Medicaid-eligible patients regardless of any other medical coverage, except for those recipients in the retroactive eligibility period. The exceptions as defined below must be well-documented and support the medical necessity for these procedures when performed on an inpatient basis.

- An existing medical condition which requires prolonged post-operative observation by skilled medical personnel (e.g., heart disease or severe diabetes).
- The recipient had been admitted to a hospital for another procedure or condition and the surgeon decides that one of the listed procedures is also necessary or is done in conjunction with the procedure requiring hospitalization.
- Another procedure which requires the inpatient setting may follow the initial procedure (e.g., gynecological laparoscopy followed by oophorectomy).

- Adequate outpatient facilities are not available within a reasonable distance (i.e., 50 miles), requiring the procedure to be rendered on an inpatient basis; in this case, a one-day inpatient hospital stay would be allowed unless a longer stay is medically necessary.

All physician claims will pend for review when the site of the service is inpatient and a listed outpatient surgical or diagnostic procedure code is used. Complete case documentation must support the medical necessity for these procedures when performed on an inpatient basis. Payment will only be approved when appropriate justification for the inpatient necessity is provided on (or accompanies) the invoice.

Sterilization

Human Reproductive Sterilization

Human reproductive sterilization is defined by the Department of Medical Assistance Services as any medical treatment, procedure, or operation for the purpose of rendering an individual permanently incapable of reproducing.

Sterilizations that are performed because pregnancy would be life-threatening to the mother ("therapeutic" sterilizations) are included in this definition. The term sterilization means only human reproductive sterilization, as defined above.

Note: Treatment which is not for the purpose of, but results in, sterility (formerly referred to as secondary sterilization) does not require completion of the Sterilization Consent Form. This applies for the purposes of payment only. Informed consent and billing requirements associated with the performance of a hysterectomy are referred to earlier in this section.

Conditions of Coverage

The conditions under which sterilization procedures for both inpatient and outpatient services are payable by the Program conform to federal regulations.

The Virginia Medicaid Program does not cover sterilization procedures for mentally incompetent or institutionalized individuals or an individual under age 21.

A sterilization will be covered under the Program only if the following conditions are met:

- The individual is at least 21 years old at the time consent for sterilization is obtained.

  Note: A patient must be 21 years old to give consent to a sterilization. This is a federal requirement for **sterilizations only** and is not affected by any other State law regarding the ability to give consent to medical treatment generally. The age limit is an **absolute** requirement. There are no exceptions for marital status, number of children, or for a therapeutic sterilization.

- The individual is not a mentally incompetent individual. For Virginia Medical Assistance Program purposes, a mentally incompetent individual is a person who has been declared mentally incompetent by the federal, State, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization. The competency requirement is an **absolute** requirement. There are no exceptions.

- The individual is able to understand the content and nature of the informed consent process as specified in this section. A patient considered mentally ill or mentally retarded may sign the consent form if it is determined by a physician that the individual is capable of understanding the nature and significance of the sterilizing procedure.

- The individual is not institutionalized. For the purposes of Medicaid reimbursement for sterilization, an institutionalized individual is a person who is:

    - Involuntarily confined or detained under civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or

    - Confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

- The individual has **voluntarily** given informed consent in accordance with all the requirements prescribed in this section.

- At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the following instances:

    - Sterilization may be performed at the time of emergency abdominal surgery if the patient consented to the sterilization at least 30 days before the intended date of sterilization and at least 72 hours have passed after written informed consent was given and the performance of the emergency surgery.

    - Sterilization may be performed at the time of premature delivery if the following requirements are met: the written informed consent was given at least 30 days before the expected date of the delivery, and at least 72 hours have passed after written informed consent to be sterilized was given.

- Regardless of the preauthorization for the hospitalization, if the invoice reflects a sterilization, the claim will pend for Medicaid manual review. If the forms are not properly completed, or not attached to the bill, the claim will be denied or reduced according to Medicaid policy.

- A completed DMAS-3004, Sterilization Consent Form must accompany all claims for sterilization services. This requirement extends to all providers:

attending physicians or surgeons, assistant surgeons, anesthesiologists, and facilities. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP). If a specialist orders services for the recipient, the MEDALLION PCP must have made the referral to the specialist. The specialist must maintain documentation of coordination of services with the MEDALLION PCP. Only claims directly related to the sterilization surgery, however, require consent documentation. Claims for presurgical visits and tests or services related to postsurgical complications do not require consent documentation.

Informed Consent Process for Sterilization

The informed consent process may be conducted either by a physician or by the physician's designee. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP).

An individual has given informed consent only if:

- The person who obtained consent for the sterilization procedure:
  - Offered to answer any questions the individual may have had concerning the sterilization procedure;
  - Provided the individual with a copy of the consent form;
  - Provided orally all of the following information to the individual to be sterilized;
    - Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally-funded program benefits to which the individual might be otherwise entitled;
    - A description of available alternative methods of family planning and birth control;
    - Advice that the sterilization procedure is considered to be irreversible;
    - A thorough explanation of the specific sterilization procedure to be performed;
    - A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
    - A full description of the benefits or advantages that may be expected as a result of the sterilization; and

- Advice that the sterilization will not be performed for at least 30 days, except under the circumstances of premature delivery or emergency abdominal surgery, in which case 72 hours must have passed between the informed consent and surgery; also, in the case of premature delivery, consent must have been given at least 30 days prior to the expected date of delivery.

- Suitable arrangements were made to ensure that the information specified above was effectively communicated to a blind, deaf, or otherwise impaired individual to be sterilized.

- An interpreter was provided if the individual to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent.

- The individual to be sterilized was permitted to have a witness of the individual's choice present when consent was obtained.

- The sterilization operation was requested without fraud, duress, or undue influence.

- All other State and local requirements were followed.

- The appropriate consent form was properly filled out and signed (see below).

- **Informed consent may not be obtained while the individual to be sterilized is**:

  - **In labor or within 24 hours postpartum or postabortion;**

  - **Seeking to obtain or obtaining an abortion; or**

    - "Seeking to obtain" means that period of time during which the abortion decision and the arrangements for the abortion are being made.

    - "Obtaining an abortion" means that period of time during which an individual is undergoing the abortion procedure, including any period during which preoperative medication is administered.

  The Virginia Medical Assistance Program prohibits the giving of consent to a sterilization at the same time a patient is seeking to obtain or obtaining an abortion. This does not mean, however, that the two procedures may never be performed at the same time. If a patient gives consent to sterilization, then later wishes to obtain an abortion, the procedures may be done concurrently. An elective abortion does not qualify as emergency abdominal surgery, and this procedure does not affect the 30-day minimum wait.

- **Under the influence of alcohol or other substances that affect the individual's state of awareness.**

Sterilization Consent Document

The only acceptable sterilization consent form is the Virginia Department of Medical Assistance Services Sterilization Consent Form (DMAS-3004). An informed consent does not exist unless this form is completed voluntarily by a person 21 years of age or over and in accordance with the following instructions. (See "Exhibits" at the end of the chapter for a sample of the form.) No payment will be made without the submission of this form completed, signed, and dated by the patient giving the consent, the person obtaining the consent, and the physician who performed the surgery. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP). If a specialist orders services for the recipient, the MEDALLION PCP must have made the referral to the specialist. The specialist must maintain documentation of coordination of services with the MEDALLION PCP. The date of the signature of the person obtaining an informed consent must be the same as the date of signature of the person giving consent. Instructions for completing the form are shown on the next page:

Instructions for Completing the Sterilization Consent Form (DMAS-3004)

Ref. No.	Blank	Instructions
1	**Doctor or Clinic**	This line may be prestamped. If the provider is a physician group, all names may appear (e.g., Drs. Miller and Smith); the professional group name may be listed (e.g., Westside Medical Group); or the phrase "and/or his/her associates" may be used
2	**Name of Operation**	If the name of the operation is lengthy, an abbreviation may be used with an asterisk. The full name of the operation should be written out at the bottom of the form.
3	**Month, Day, Year**	Enter the patient's birth date. This information is required.
4	**Patient name**	Must be completed. The name used should be identical to the patient name appearing on the claim form.
5	**Doctor**	May be prestamped. If a group, all names may be listed, or the phrase "and/or his/her associates."
6	**Name of Operation**	Enter the name of the operation. If the name of the operation is lengthy, an abbreviation may be used with an asterisk. The full name of the operation should be written out at the bottom of the form.
7	**Signature**	The patient must sign here. If the patient is illiterate, the form of signature permitted is an "X," which must be countersigned by a witness.
8	**Month, Day, Year**	Patient's signature must be dated. The waiting period is calculated from this date.
9	**Ethnic Designation**	This information is voluntary and should be completed only by the patient.
10	**Language**	Indicate the language in which the patient was counseled, if other than English.
11	**Interpreter's Signature**	Must be signed if an interpreter was used.
12	**Month, Day, Year**	Interpreter's signature must be dated.
13	**Name of Individual**	Enter the patient's name here.

Ref. No.	Blank	Instructions
14	**Name of Operation**	If the name of the operation is lengthy, an abbreviation may be used with an asterisk. The full name of the operation should be written out at the bottom of the form.
15	**Person Obtaining Consent**	The person providing sterilization counseling may be a physician or the physician's designee (e.g., an office nurse). Once this section is completed, the patient should be given a copy of the form.
16	**Month, Day, Year**	Signature of the person obtaining consent must be dated.
17	**Facility**	May be prestamped.
18	**Address**	May be prestamped.
19	**Name of Patient**	Enter the patient's name.
20	**Date of Operation**	Enter the date of the operation.
21	**Type of Operation**	If the name of the operation is lengthy, an abbreviation may be used with an asterisk. The full name of the operation should be written out at the bottom of the form. Consent is not invalidated if the operation actually performed differs from the method of sterilization originally planned.
22-23	**Final Paragraphs**	Cross-out the paragraph **not** used. The minimum waiting period is 30 days from the date consent was given, except in cases of premature delivery or emergency abdominal surgery.
24	**Premature Delivery**	If this box is checked, a date of expected delivery must be present in Item 25.
25	**Individual's Expected Date of Delivery**	The date estimated by physician based on the patient's history
26	**Emergency Abdominal Surgery**	Indicate the operation performed.
27	**Physician Signature**	Must be completed **after** the sterilization operation, by the physician who has verified consent and who actually

Ref. No.	Blank	Instructions
		performs the operation. The purpose of obtaining consent "shortly before" the operation is to reaffirm consent. This may be done while the patient is in labor or after delivery. In this context, "shortly before" means up to 72 hours prior to the operation.
28	**Month, Day, Year**	The physician's signature must be dated.

Use of the Sterilization Consent Form

The consent form must be signed and dated by the following:

- The individual to be sterilized;
- The interpreter, if one is provided;
- The individual who obtains the consent; and
- The physician who will perform the sterilization procedure.

The person securing the consent shall certify by signing the consent form that he or she:

- Advised the individual to be sterilized, before the individual to be sterilized signed the consent form, that no federal benefits may be withdrawn because of the decision not to be sterilized;
- Explained orally the requirements for informed consent to the individual to be sterilized as set forth on the consent form and in regulations; and
- Determined to the best of his/her knowledge and belief that the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.

If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP). If a specialist orders services for the recipient, the MEDALLION PCP must have made the referral to the specialist. The specialist must maintain documentation of coordination of services with the MEDALLION PCP. The physician performing the sterilization shall certify by signing the consent form that:

- The physician, shortly before the performance of the sterilization, advised the individual to be sterilized that federal benefits shall not be withheld or withdrawn because of a decision not to be sterilized. (For Program purposes, the phrase "shortly before" means a period within 72 hours prior to the time the patient receives any preoperative medication.)

- The physician explained orally the requirements for informed consent as set forth on the consent form.

- To the best of the physician's knowledge and belief, the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.

- At least 30 days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed, except in the following instances:

    - Sterilization may be performed at the time of emergency abdominal surgery if the physician certifies that the patient consented to the sterilization at least 30 days before he or she intended to be sterilized; that at least 72 hours have passed after written informed consent to be sterilized was given; and the physician describes the emergency on the consent form.

    - Sterilization may be performed at the time of premature delivery if the physician certifies that the written informed consent was given at least 30 days before the **expected** date of the delivery. The physician shall state the expected date of the delivery on the consent form. At least 72 hours have passed after written informed consent to be sterilized was given.

The interpreter, if one is provided, shall certify that he or she:

- Transmitted the information and advice concerning the sterilization procedure and possible complications orally to the individual to be sterilized;

- Read the consent form and explained its contents to the individual to be sterilized; and

- Determined to the best of his or her knowledge and belief that the individual to be sterilized understood what the interpreter told the individual.

A copy of the signed consent form must be:

- Provided to the patient;

- Retained by the physician and the hospital in the patient's medical records; and

- Attached to all claims for sterilization services. In addition, no sterilization procedure will be covered by Virginia Medicaid unless a copy of the Department of Medical Assistance Services Form (DMAS-3004) is attached to the invoice submitted by each provider, including the surgeon, assistant surgeon, anesthesiologist, hospital, or outpatient clinic in order that each claim might be evaluated. **The DMAS-3004 is the only consent form that will be accepted by Medicaid, and no payment will be made without submission of this form by each provider involved in the sterilization procedure.** Only claims

directly related to the sterilization surgery, however, require consent documentation. Claims for presurgical visits and tests or services related to post-surgical complications do not require consent documentation.

Claims for Service

Any claim submitted without a properly-executed consent form or documentation showing medical necessity will be pended. If appropriate information is not received within 30 days of the request for the information, the claim will be denied. The originating physician is required to supply a copy of the DMAS-3004 to other billing providers. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP), or there must be a referral for the service from the MEDALLION PCP.

CPT/HCPCS Sterilization Procedure Codes

55200 Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)

55250 Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)

55450 Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure)

56301 Laparoscopy, surgical; with fulguration of oviducts (with or without transection)

56302 Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip, or Falope ring)

56307 Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)

58600 Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral

58605 Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)

58611 Ligation or transection of fallopian tube(s) when done at the time of cesarean section or intra-abdominal surgery

58615 Occlusion of fallopian tube(s) by device (e.g., band, clip, or Falope ring), vaginal or suprapubic approach

58700 Salpingectomy, complete or partial, unilateral or bilateral

58720 Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

59100 Hysterotomy, abdominal (e.g., for hydatidiform mole, abortion)

Retroactive Coverage

Providers are reminded that sterilization is covered only if all applicable requirements are met at the time the operation is performed. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP). This includes:

- The requirements related to the time period required between the date of informed consent and the date of sterilization;
- The informed consent requirements for the individual to be sterilized; and
- The certification requirements for signatures of the individual to be sterilized, the interpreter (if applicable), the person obtaining consent, and the physician who performed the sterilization procedure that must be present on the DMAS-3004.

If a patient obtains retroactive Program coverage, previously provided sterilization services cannot be billed unless the applicable requirements have been met. There are no exceptions made for retroactive eligibility in regard to the requirements for sterilization.

Surgery for Morbid Obesity

If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP), or there must be a referral for the service from the MEDALLION PCP.

This type of surgery may be covered **only when all other treatment has failed and prior approval has been obtained from the Program.** All requests for prior authorization should be directed to:

Director of Medical Support
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

A copy of the authorization must be attached to the claim form to obtain payment.

VACCINES

For eligible recipients, routine immunizations are routinely covered only under Virginia Medicaid's EPSDT program. Immunizations to all other individuals are limited except for instances when:

- It is necessary for the direct treatment of an injury, or

- The immunization is a pneumococcal or influenza vaccination that is reasonable and necessary for the prevention of illness.

Physicians can be reimbursed for the cost of pneumococcal or influenza vaccines given as part of a plan of treatment which has as its objective preventing the occurrence of more serious illness in an individual "at risk." This allows for the administration of influenza and/or pneumococcal vaccinations when these vaccinations are indicated as medically necessary. The medical treatment record, upon review, must clearly indicate the valid medical reason(s) justifying the administration of these vaccines.

VACCINES FOR CHILDREN PROGRAM

The Vaccines for Children (VFC) Program provides routine childhood vaccinations free of charge to Medicaid-eligible children up to the age of 19. These vaccines will be provided by the Virginia Department of Health (VDH).

Requirement to Enroll in VFC

To participate, a provider must complete the enrollment and provider profile forms provided by VDH. At this point, the provider is eligible to receive free vaccines under the VFC. Upon enrollment, the Department of Medical Assistance Services will not reimburse the provider for the acquisition cost for vaccines covered under VFC. Medicaid will reimburse providers the administration fee for routine childhood vaccines that are available under VFC (up to the age of 19). Medicaid will reimburse the provider an administration fee per injection.

Billing Codes for the Administration Fee

Providers must use Medicaid-specific billing codes when billing Medicaid for the administration fee for free vaccines under VFC. These codes identify the VFC vaccine provided and will assist VDH with its accountability plan which the Health Care Financing Administration (HCFA) requires. The billing codes are:

Y0013	Diphtheria Tetanus & Pertussis
Y0014	Diphtheria Tetanus & Acellular Pertussis
Y0015	Tetanus Diphtheria - Adult
Y0016	Tetanus Diphtheria - Pediatric
Y0017	Combined Diphtheria Tetanus Pertussis & Haemophilus Influenzae b
Y0018	Haemophilus Influenzae b
Y0019	Hepatitis B - Adult
Y0020	Hepatitis B - Pediatric
Y0021	Oral Polio
Y0022	Inactivated Polio
Y0023	Measles Mumps & Rubella
Y0024	Measles Rubella
Y0025	Measles
Y0026	Mumps
Y0027	Rubella

Y0028	Varicella - Chickenpox
Y0029	Influenza
Y0030	Pneumococcal
Y0031	Hepatitis B - Adolescent
Y0033	ComVax Hepatitis B and HiB

If the provider chooses to provide a single antigen vaccine, such as measles, mumps, or rubella, medical justification which documents the medical necessity of providing a single antigen vaccine when the combined-antigen vaccine is available must be attached to the claim. Claims for measles, mumps, or rubella vaccines will automatically pend for review by Medicaid staff. See the section on "Single Antigen Vaccines" below. Medicaid does not reimburse for influenza and pneumococcal vaccines except when they are reasonable and necessary for the prevention of illness. The physician's treatment plan must have as its objective preventing the occurrence of more serious illness in an individual "at risk." This allows for the provision of influenza and/or pneumococcal vaccines when they are indicated as medically necessary. The medical treatment record must clearly indicate the valid medical reason(s) justifying the administration of these vaccines.

Reimbursement for Children Ages 19 and 20

Since Medicaid policy provides coverage for vaccines for children up to the age of 21, and VFC provides coverage only up to the age of 19, there may be instances where the provider will provide immunizations to children who are ages 19 and 20. Bill Medicaid with the appropriate CPT/HCPCS code, and Medicaid will reimburse the acquisition cost for these vaccines. Medicaid will not reimburse an administration fee since these vaccines were not provided under the VFC Program to this age group.

Office Visits Billed in Conjunction with Immunizations

Medicaid will reimburse physicians an appropriate minimal office visit (e.g., CPT/HCPCS code 99211), in addition to the administration fee or acquisition cost as appropriate (only for ages 19 and 20), when an immunization is the only service performed.

Vaccines Not Available Under VFC

The Virginia Department of Health has no contracts with the Centers for Disease Control (CDC) for the VFC distributor to provide Diphtheria Tetanus and Pertussis (DTP) and Hepatitis B for dialysis patients. Therefore, Medicaid will reimburse for the acquisition cost for these vaccines under CPT codes 90701 and 90747, respectively. No administration fee will be reimbursed under code Y0032 since this vaccine is not available under VFC.

Single Antigen Vaccines

Single antigen vaccines (such as measles, mumps, and rubella) are available from the VFC contractor but must be ordered by the provider with special justification since the combined antigen vaccine (MMR) is available. This is consistent with Medicaid policy to require medical justification for single antigen vaccines.

Pneumococcal and Influenza Vaccines

The VFC Program provides coverage for the pneumococcal and influenza vaccines for high-risk patients only. When ordering these vaccines through the health department, the provider must provide medical justification. Medicaid will provide reimbursement for these vaccines only if they are reasonable and necessary for the prevention of illness. Medical justification does not need to be attached to the claim, but the physician's treatment plan on file in the patient's medical record must indicate that the vaccine was provided to prevent the occurrence of more serious illness in an individual "at risk."

Situations Where Vaccines Are Not Covered Under VFC

There may be some situations where a child is attempting to "catch-up" on vaccines that have been missed. In some cases, the VFC program will not provide coverage for these "catch-up" vaccines, and the provider will have to purchase them from his or her normal vaccine distributor. If this occurs, Medicaid will continue to reimburse the provider for the acquisition cost of these vaccines as long as there is information attached to the claim indicating the reason for billing Medicaid for the acquisition cost. In addition to the attachment to the claim, use modifier 22 in Block 24-D of the HCFA-1500 (12-90) claim form.

Vaccines Provided Outside of the EPSDT Periodicity Schedule

Virginia Medicaid covers childhood immunizations under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program based upon a periodicity schedule. This schedule was developed by the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics along with representatives from the American Academy of Family Physicians. See *Supplement B - EPSDT* for a copy of the immunization schedule. If the provider provides a vaccine to a child that falls outside of this immunization schedule and the vaccine does not meet the criteria for coverage under the VFC Program, Medicaid cannot reimburse for immunizations unless documentation is sent along with the claim to explain the circumstances under which the vaccine was provided. In addition to the attachment to the claim, use modifier 22 in Locator 24-D to bill Medicaid for the acquisition cost.

Questions

For questions relating specifically to the VFC program, call the Virginia Department of Health Hotline at 1-800-568-1929. The VDH Hotline is available Monday through Friday from 7:00 a.m. to 5:00 p.m. For other questions, call the Medicaid HELPLINE.

ORTHOTICS

Orthotic device services include devices that support or align extremities to prevent or correct deformities or to improve functioning, and services necessary to design the device, including measuring, fitting, and instructing the patient in its use. These services must be ordered by a physician. If the recipient is enrolled in MEDALLION, the ordering physician

must be the MEDALLION primary care physician (PCP), or there must be a referral for the service from the MEDALLION PCP.

HMOs must provide medically necessary orthotic services at least to the extent covered under Medicaid guidelines and may have their own medical criteria and preauthorization procedures.

Practitioners may bill for supplies and equipment, beyond those routinely included in the office visit, when used in the course of treatment in the practitioner's office. These supplies include ace bandage, sling, splint, rib belt, cervical collar, lumbosacral support, etc. The applicable CPT/HCPCS code may be used when billing for a specific supply item used.

Orthotics, including braces, splints, and supports, are not covered for the general adult Medicaid population under the Durable Medical Equipment (DME) Program.

DME and supplies may also be covered through such programs as EPSDT, some of the waiver programs under the Community-Based Care Services, and for recipients being discharged from an intensive (often inpatient) rehabilitation program. Additionally, the recipient may receive orthotics (i.e., non-custom orthotics) through his or her practitioner during an office visit.

Rehabilitation Program

Items made for the recipient by an occupational therapist, including splints, slings, and any normally stocked supplies, are part of the cost of the Medicaid-approved rehabilitation visit. These items are billed as ancillary charges on the UB-92 (HCFA-1450).

Intensive Rehabilitation

Coverage is available for medically necessary orthotics, when recommended as part of an approved intensive rehabilitation program and when the following criteria are satisfied via adequate and verifiable documentation. Orthotics must be:

- Ordered by the physician on the DMAS-352 (CMN). If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP). If a specialist orders services for the recipient, the MEDALLION PCP must have made the referral to the specialist. The specialist must maintain documentation of coordination of services with the MEDALLION PCP;

- Directly and specifically related to an active, written, and physician-approved treatment or discharge plan;

- Based upon a physician's assessment of the recipient's rehabilitation potential where the recipient's condition will improve significantly in a reasonable and predictable period of time, or must be necessary to establish an improved functional state of maintenance; and

- Consistent with generally accepted professional medical standards (i.e., not experimental or investigational).

The orthotist participating as a Medicaid DME provider coordinates the completion of the DMAS-352 (CMN) with the prescribing physician, using the correct HCPCS "L" procedure codes. Preauthorization is required and may be submitted either telephonically or on a DMAS-351 preauthorization request form. Documentation of the provider cost will be required for "L" procedure codes that do not have an established reimbursement allowance. Reimbursement (under the HCPCS "L" codes) to the DME orthotic provider is all inclusive; no supplemental reimbursement will be made for the time involved in fitting, measuring, and designing the orthotic, or for providing the recipient with instructions for the proper use.

EPSDT (Children Under 21 Years of Age)

Children do not have to be enrolled in Children's Specialty Services to receive orthotics. All medically necessary orthotics are covered for children under the age of 21 years. The orthotist participating as a Medicaid DME provider coordinates the completion of the DMAS-352 (CMN) with the prescribing physician using the correct HCPCS "L" procedure codes. If the recipient is enrolled in MEDALLION, the ordering physician must be the MEDALLION primary care physician (PCP). If a specialist orders services for the recipient, the MEDALLION PCP must have made the referral to the specialist. The specialist must maintain documentation of coordination of services with the MEDALLION PCP. Preauthorization is required and may be submitted either telephonically or on a DMAS-351 preauthorization request form. Documentation of provider cost will be required for "L" procedure codes that do not have an established reimbursement allowance. Reimbursement (under HCPCS "L" codes) to the DME orthotic provider is all inclusive; no supplemental reimbursement will be made for the time involved in fitting, measuring, and designing the orthotic, or for providing the recipient with instructions for the proper use.

Preauthorization

Orthotic requests must be made by an orthotist participating as a Medicaid DME provider. For specific information on the procedure, see "PREAUTHORIZATION" below. DME (orthotic) providers make facsimile or mail requests for preauthorization directly to DMAS. To submit a preauthorization request on paper, the DME (orthotic) provider must send the DMAS-351 Preauthorization Request form and the supporting documentation to First Health Services Corporation, the Medicaid fiscal agent.

PREAUTHORIZATION

The Department of Medical Assistance Services uses the services of a private contractor to preauthorize durable medical equipment and supplies, dental services, home health services, hospice services, and rehabilitation services. The contractor is WVMI, which maintains offices in Richmond. WVMI reviews all preauthorization requests regardless of the date(s) of service. Only the appropriate provider may call for prior authorization (i.e., rehab providers for rehab, DME providers for DME, etc., and not the physician for these programs). Other preauthorization services follow the procedures as outlined in the specific provider manuals.

Effective January 1, 2003, all Outpatient Psychiatric Services and Orthotic Services will be preauthorized by DMAS.

The Medicaid Long Term Care staff reviews intensive rehabilitation services requests for ventilator-dependent recipients, and out-of-state placements. The preauthorization process for these services remains the same.

Medicaid conducts quality utilization management (UM) audits on a regular basis.

Providers have an option of submitting preauthorization requests for most services either telephonically or on paper. Outpatient rehabilitation requests must be submitted telephonically (effective for requests made on or after October 1, 1998). Preauthorizations for the following services **must** be preauthorized by paper: all dental requests, home health requests for comprehensive nursing visits, DME unpriced codes for amounts over $3,500, DME specialized wheelchairs, and DME ventilator purchase requests (except CPAPs and BiPAPs).

To make a telephonic request, call WVMI and provide the information requested by the WVMI analyst. The WVMI analyst will approve, deny, or pend the request. While on the line, the analyst will provide an authorization number for approved services which is required to bill Medicaid. WVMI will also send the provider a letter validating the action taken by the analyst (approve, deny, or pend).

For Outpatient Psychiatric Services and Orthotic Services, contact DMAS and provide the information requested by the DMAS analyst. The DMAS analyst will approve, pend, or deny the request. While on the line, the analyst will provide an authorization number for approved services which is required to bill Medicaid. DMAS will also send the provider a letter validating the action taken by the analyst (approve, pend or deny).

To submit a preauthorization request on paper, mail the DMAS-351 Preauthorization Request form (See "Exhibits" at the end of the chapter for a sample of the form) and supporting documentation to FIRST HEALTH Services Corporation, the Medicaid fiscal agent. The address is:

FIRST HEALTH Services Corporation
P. O. Box 27444
Richmond, Virginia 23261-7444

FIRST HEALTH Services Corporation will enter the paper request for preauthorization and forward it to WVMI. Make telephonic requests for preauthorization directly to WVMI at the following telephone numbers:

(804) 648-3159 Richmond Area
(800) 299-9864 All Other Areas

Make telephonic requests for preauthorization of Outpatient Psychiatric Services directly to DMAS at the following telephone number:

(804) 225-3536

Make facsimile requests for Outpatient Psychiatric Services and Orthotic Services directly to DMAS at the following numbers:

(804) 225-2603
(866) 248-8796 (toll free)

Make mailed requests for Outpatient Psychiatric Services and Orthotic Services directly to DMAS at the following address:

Department of Medical Assistance Services
Attn: Payment Processing Unit
600 E. Broad Street
Richmond, VA 23219

All requests for preauthorization of Orthotic Services must be faxed or mailed.

The turnaround time is about two weeks for providers receiving a response to a paper preauthorization request. In most cases, WVMI or DMAS (as is applicable) will provide an immediate response to telephonic requests.

Mail pend responses and reconsideration requests directly to WVMI. The address is:

WVMI
6802 Paragon Place, Suite 410
Richmond, Virginia 232230

Mail pend responses and reconsideration requests for Outpatient Psychiatric Services and Orthotic Services directly to DMAS. The address is:

Department of Medical Assistance Services
Attn: Payment Processing Unit
600 E. Broad Street
Richmond, VA 23219

Direct all telephone inquiries regarding the preauthorization status concerning DME, dental services, home health services, hospice services, outpatient psychiatric services, and rehabilitation services to the provider HELPLINE (786-6273 for the Richmond area and 1-800-552-8627 for all other areas). Information pertaining to preauthorization status is no longer available to other Medicaid staff.

If the WVMI review analyst denies the services and the provider wants to request reconsideration of the denial, the provider must follow the reconsideration process. If a telephone request is denied by the WVMI review analyst, the provider must request telephonic reconsideration by the WVMI Preauthorization Supervisor within 30 days of the denial. If a written request is denied by the WVMI analyst, the provider must submit a letter

to the WVMI Preauthorization Supervisor requesting reconsideration within 30 days of the notice of denial.

If the DMAS review analyst denies the services and the provider wants to request reconsideration of the denial, the provider must follow the reconsideration process. If a telephone request is denied by the DMAS review analyst, the provider must request written reconsideration by the DMAS Payment Processing Supervisor within 30 days of the denial. If a written request is denied by the DMAS review analyst, the provider must submit a letter to the DMAS Payment Processing Supervisor requesting reconsideration within 30 days of the notice of denial.

After the completion of the reconsideration process, the denial of preauthorization for services not yet rendered may be appealed in writing by the Medicaid recipient within 30 days of the written notification of denial. If the preauthorization denial is for a service that has already been rendered, the provider may appeal the adverse decision in writing within 30 days of the written notification of denial of reconsideration. Address all written appeals to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

PROCEDURE CODES REQUIRING PREAUTHORIZATION BY MEDICAID MEDICAL SUPPORT

CPT code	Code Description
	Anesthesia
00402	Anesthesia for procedures on anterior integumentary system of chest, including subcutaneous tissue; reconstructive procedures on breast (e.g., reduction or augmentation mammoplasty, muscle flaps)
00938	Anesthesia for procedures on male external genitalia; insertion of penile prosthesis (perineal approach)
	Integumentary System
11970	Replacement of tissue expander with permanent prosthesis
15831	Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen (abdominoplasty)

15832	thigh
15833	leg
15834	hip
15835	buttock
15836	arm
15837	forearm or hand
15838	submental fat pad
15839	other area
19140	Mastectomy for gynecomastia
19316	Mastopexy
19318	Reduction mammaplasty
19324	Mammaplasty, augmentation; without prosthetic implant
19325	with prosthetic implant
19328	Removal of intact mammary implant
19330	Removal of mammary implant material
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19350	Nipple/areola reconstruction
19355	Correction of inverted nipple
19357	Breast reconstruction, immediate or delayed, with tissue expander, including

subsequent expansion

19361 Breast reconstruction with latissimus dorsi flap, with or without prosthetic implant

19364 Breast reconstruction with free flap

19366 Breast reconstruction with other technique

19367 Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;

19368 with microvascular anastomosis (supercharging)

19369 Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site

19380 Revision of reconstructed breast

19396 Preparation of moulage for custom breast implant

Musculoskeletal System

20974 Electrical stimulation to aid bone healing; noninvasive (nonoperative)

20975 invasive (operative)

21121 Genioplasty; sliding osteotomy, single piece

21122 sliding osteotomies, two or more osteotomies (e.g., wedge resection or bone wedge reversal for asymmetrical chin)

21123 sliding, augmentation with interpositional bone graft (including obtaining autografts)

21125 Augmentation, mandibular body or angle; prosthetic material

21127 with bone graft, onlay or interpositional (including obtaining autograft)

21240 Arthroplasty, temporomandibular joint, with or without autograft (including obtaining

graft)

21242 Arthroplasty, temporomandibular joint, with allograft

21243 Arthroplasty, temporomandibular joint, with prosthetic joint replacement

Respiratory System:

30220 Insertion, nasal septal prosthesis (button)

30400 Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip

30410 complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip

30420 including major septal repair

30430 Rhinoplasty, secondary; minor revision (small amount of nasal tip work)

30435 intermediate revision (bony work with osteotomies)

30450 major revision (nasal tip work and osteotomies)

30520 Septoplasty or submucous resection, with or without cartilage scoring, contouring, or replacement with graft

Cardiovascular System:

33970 Insertion of intra-aortic balloon assist device through the femoral artery, open approach

33973 Insertion of intra-aortic balloon assist device through the ascending aorta

33975 Implantation of ventricular assist device; single ventricle support

33976 biventricular support

Digestive System

41820	Gingivectomy, excision gingiva, each quadrant
41821	Operculectomy, excision pericoronal tissues
41828	Excision of hyperplastic alveolar mucosa, each quadrant (specify)
41830	Alveolectomy, including curettage of osteitis or sequestrectomy
41870	Periodontal mucosal grafting
41872	Gingivoplasty, each quadrant (specify)
41874	Alveoloplasty, each quadrant (specify)
42145	Palatopharyngoplasty (e.g., uvulopalatopharynoplasty, uvulopharyngoplasty)
42280	Maxillary impression for palatal prosthesis
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
43843	other than vertical-banded gastroplasty
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (less than 100 cm) Roux-en-Y gastroenterostomy
43847	with small bowel reconstruction to limit absorption
43848	Revision of gastric restrictive procedure for morbid obesity (separate procedure)
46750	Sphincteroplasty, anal, for incontinence or prolapse; adult
46751	child

Urinary System

53445	Operation for correction of urinary incontinence with placement of inflatable urethral or bladder neck sphincter, including placement of pump and/or reservoir

53447 Removal, repair, or replacement of inflatable sphincter including pump and/or reservoir and/or cuff

53449 Surgical correction of hydraulic abnormality of inflatable sphincter device

Male Genital System:

54400 Insertion of penile prosthesis; non-inflatable (semi-rigid)

54401 inflatable (self-contained)

54402 Removal or replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis

54405 Insertion of inflatable (multi-component) penile prosthesis, including placement of pump, cylinders, and/or reservoir

54407 Removal, repair, or replacement of inflatable (multi-component) penile prosthesis, including pump and/or reservoir and/or cylinders

54409 Surgical correction of hydraulic abnormality of inflatable (multi-component) prosthesis including pump and/or reservoir and/or cylinders

55175 Scrotoplasty; simple

55180 complicated

Eye and Ocular System

67900 Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

67901 Repair of blepharoptosis; frontalis muscle technique with suture or other material

67902 frontalis muscle technique with fascial sling (includes obtaining fascia)

67903 (tarso)levator resection or advancement, internal approach

67904 (tarso)levator resection or advancement, external approach

67906 superior rectus technique with fascial sling (includes obtaining fascia)

67908 conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type)

Auditory System

69300 Otoplasty, protruding ear, with or without size reduction

69710 Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone

69711 Removal or repair of electromagnetic bone conduction hearing device in temporal bone

69930 Cochlear device implantation , with or without mastoidectomy

Contact Lens Services:
These codes are limited to Medicaid recipients under the age of 21 years of age.

92310 Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia

92311 corneal lens for aphakia, one eye

92312 corneal lens for aphakia, both eyes

92313 corneoscleral lens

92314 Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes except for aphakia

92315 corneal lens for aphakia, one eye

92316 corneal lens for aphakia, both eyes

92317 corneoscleral lens

92395 Supply of permanent prosthesis for aphakia; spectacles

92396 contact lenses

Orthotic Procedures:

All HCPCS codes for **orthotic procedures** must be preauthorized. The range for these codes is L0100 through L4398.

Prosthetic Procedures:

All HCPS codes for **prosthetic procedures** must be preauthorized. The range for these codes is L5000 through L8499

Transplant Procedures:

All **organ transplants** must be preauthorized except for corneal.

TRANSPLANT PROCEDURE CODE:

From CPT' 1994-98:

ANESTHESIA:

00580 Anesthesia for heart transplant or heart/lung transplant

00796 Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; liver transplant (recipient)

00862 Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; renal procedures, including upper 1/3 of ureter, or donor nephrectomy

00868 renal transplant (recipient)

01990 Physiological support for harvesting of organ(s) from brain-dead patient

LUNG:

32850 Donor pneumonectomy(ies) with preparation and maintenance of allograft (cadaver)

32851 Lung transplant, single, without cardiopulmonary bypass

32852 with cardiopulmonary bypass

32853 Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass

32854 with cardiopulmonary bypass

HEART:

33930 Donor cardiectomy-pneumonectomy, with preparation and maintenance of allograft

33935 Heart-lung transplant with recipient cardiectomy-pneumonectomy

33940 Donor cardiectomy, with preparation and maintenance of allograft

33945 Heart transplant, with or without recipient cardiectomy

BONE MARROW:

38230 Bone marrow harvesting for transplantation

38231 Blood-derived peripheral stem cell harvesting for transplantation, per collection

38240 Bone marrow or blood-derived peripheral stem cell transplantation; allogenic

38241 autologous

LIVER:

47133 Donor hepatectomy, with preparation and maintenance of allograft; from cadaver donor

47134 partial, from living donor

47135 Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age

47136 heterotopic, partial or whole, from cadaver or living donor, any age

PANCREAS:

48160 Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islets

48550 Donor pancreatectomy, with preparation and maintenance of allograft from cadaver donor, with or without duodenal segment for transplantation

48554 Transplantation of pancreatic allograft

KIDNEY:

50300 Donor nephrectomy, with preparation and maintenance of allograft; from cadaver donor, unilateral or bilateral

50320 from living donor

50340 Recipient nephrectomy (separate procedure)

50360 Renal allotransplantation, implantation of graft; excluding donor and recipient nephrectomy

50365 with recipient nephrectomy

50380 Renal autotransplantation, reimplantation of kidney

PARATHYROID:

60512 Parathyroid autotransplantation

From ICD-9 Procedure Codes:

THYROID:

06.94 Thyroid tissue reimplantation

PARATHYROID:

06.95 Parathyroid tissue reimplantation

THYMUS:

07.94	Transplantation of thymus

LUNG:

33.5	Lung transplant
33.50	Lung transplantation, not otherwise specified
33.51	Unilateral lung transplantation
33.52	Bilateral lung transplantation
33.6	Combined heart-lung transplantation

HEART:

33.6	Combined heart-lung transplantation
37.5	Heart transplantation

BONE MARROW:

41.0	Bone marrow or hematopoietic stem cell transplant
41.00	Bone marrow transplant, not otherwise specified
41.01	Autologous bone marrow transplant
41.02	Allogeneic bone marrow transplant with purging
41.03	Allogeneic bone marrow transplant without purging
41.04	Autologous hematopoietic stem cell transplant
41.05	Allogeneic hematopoietic stem cell transplant
41.06	Cord blood stem cell transplant
41.91	Aspiration of bone marrow from donor for transplant

SPLEEN:

41.94 Transplantation of spleen

LIVER:

50.5 Liver transplant

50.51 Auxiliary liver transplant

50.59 Other liver transplant of liver

PANCREAS:

52.8 Transplant of pancreas

52.80 Pancreatic transplant, not otherwise specified

52.81 Reimplantation of pancreatic tissue

52.82 Homotransplant of pancreas

52.83 Heterotransplant of pancreas

52.84 Autotransplantation of cells of Islets of Langerhans

52.85 Allotransplantation of cells of Islets of Langerhans

52.86 Transplantation of cells of Islets of Langerhans, not otherwise specified

KIDNEY:

55.6 Transplant of kidney

55.61 Renal autotransplantation

55.69 Other kidney transplantation

55.97 Implantation or replacement of mechanical kidney

REIMBURSEMENT

Payments for covered services submitted by physicians are based on the individual physician's usual and customary fees, within Program limitations.

Reimbursement for the administration of vaccines/immunizations is included in the office visit when a medical service is rendered. When an immunization is the only service performed, an appropriate minimal office visit (e.g., CPT/HCPCS code 99211), may be listed in addition to the injection. When billing for immunizations, only the actual acquisition cost of the injectable is to be billed separately using the appropriate CPT/HCPCS code.

Special supplies beyond those routinely included in the office visit are to be billed reflecting the provider's acquisition cost and using the special supply codes indicated on Page 54 of this chapter.

When there are extenuating circumstances, individual consideration, if requested, is given to additional allowances in compensation. However, payment by Medicaid cannot exceed the Medicare allowance for the same or similar service. It should be noted that the payment allowance for covered professional services includes the necessary administrative services as required for the care of a recipient, i.e., the preparation of records, plan of treatment, certification for services, etc. Therefore, separate payment, in addition to the professional visit, will not be made for these services.

To request individual consideration, enter "ATTACHMENT" in Locator 10D and procedure modifier "22" ("Unusual Service") in Locator 24D of the HCFA-1500 (12-90) claim form, and attach sufficient documentation to support the claim that is being billed.

Payment Basis

Payment for physician services is the lowest of the Program's fee schedule, actual charge, or Medicare allowances.

Payment in Full

In accepting payment from the Program, a physician must agree to accept Program payment as payment in full for all covered services rendered to the patient and billed to the Program. The physician may not bill Medicaid or the recipient for the difference (if any) between the allowed charge and the actual billed charge. The provider may not bill the recipient for missed or broken appointments.

The physician must bill any other possibly liable third-party payer prior to billing the Program. The Program will pay the difference between the Program's allowable fee and the amount paid by another third party, except for Medicare.

When Medicare (Title XVIII) makes a payment for physician's covered services, the physician may claim payment of any deductible and coinsurance amounts due from the Program. However, he or she may not claim payment of the difference (if any) between the Medicare-allowed fee and his or her actual fee for services. Also, Medicaid payments for Medicare Part B coinsurance are limited to the difference between Medicaid's maximum fee for a given procedure and 80 per cent of Medicare's allowance (effective January 1, 1991). The combined payments by Medicare and Medicaid will not exceed Medicaid's allowed charge for that procedure.

Implementation of a New Physician Fee Schedule

The fee schedule is based in many respects on the Medicare Resource Based Relative Value Scale (RBRVS) fee schedule. Fees for "evaluation and management" types of procedures showed an increase while many surgical and diagnostic fees declined (effective July 1, 1995). The calculation of RBRVS fees for Virginia Medicaid uses Medicare's Relative Value Units (RVUs) and Conversion Factors (CFs), with an additional adjustment to all resulting fees to ensure that total Medicaid expenditures do not increase solely due to the conversion to the new fee schedule. This schedule occurred over a three-year phase-in. Effective July 1, 1995, the blend was 1/3 the new RBRVS and 2/3 the existing Medicaid fees. Effective July 1, 1996, the blend changed to 2/3 RBRVS and 1/3 previous Medicaid fees.

Effective July 1, 1997, the fees are entirely based on the RBRVS. Starting with 1996, the Medicaid fee schedule is and will continue to be updated each January to reflect modifications to the Medicare Relative Value Units (RVUs).

Adjusting fees for Geographic Practice Cost Indices (GPCIs) will not be part of the Medicaid fee schedule. Medicaid fees will continue to be applied on a statewide basis. The payment rules adopted by Medicare at the time RBRVS was first implemented have not been adopted by Medicaid.

COPAYMENT REQUIREMENTS

As required by the Appropriations Act of 1992, the copays are the same for categorically needy recipients, Qualified Medicare Beneficiaries (QMBs), and medically needy recipients. The services and copay amounts are:

SERVICE	COPAY AMOUNT
Inpatient hospital	$100.00 per admission
Outpatient hospital clinic	3.00 per visit
Clinic visit	1.00 per visit
Physician office visit	1.00 per visit
Other physician visit	3.00 per visit
Eye examination	1.00 per examination
Prescription	1.00 for multi-source generic; 2.00 for brand per prescription or refill for dates of service on or after September 1, 2002
Home health visit	3.00 per visit
Rehabilitation service	3.00 per visit

For purposes of copays, a visit is defined as a patient encounter in the place of treatment, by the same provider on the same day regardless of the number of procedures performed. The encounter may be indirect. For example, if on July 15, 1998, the physician in a hospital performs an interpretation and report for an electrocardiogram (CPT/HCPCS code 93010) and an interpretation and report for an electrocardiogram (CPT/HCPCS code 93018), this would be considered one visit and would be subject to a $3.00 copay for a recipient who was not exempt. If the physician performed one procedure on July 15, 1998, and the other on July 16, 1998, the procedures would be considered two visits and would be subject to two $3.00 copays.

The copays apply to all recipients except the following:

- Children under 21 years of age (identified by a Special Indicator code "A" on their Medicaid identification cards);
- Individuals receiving long-term care service or hospice care (identified by a Special Indicator code "B" on their Medicaid identification cards); and
- Individuals participating in health maintenance organizations under the Managed Care program.

The following services are never subject to copays:

- Emergency services;
- Family planning services; and
- Pregnancy-related services (services delivered to pregnant women if such services are related to the pregnancy or to any other medical condition which may complicate the pregnancy, e.g., prenatal, delivery, postpartum care.)

A provider may not deny services to a recipient solely because of his or her inability to pay any applicable copayment charge. This does not relieve the recipient of the responsibility to pay nor does it prevent the provider from attempting to collect any applicable copayment from the recipient.

HMO Copayments

When billing Medicaid for the copayment for Medicaid recipients who have a Health Maintenance Organization (HMO) as their primary insurer, use the special Medicaid HCPCS/CPT code Z9988 in Block 24D of the HCFA-1500 (12-90) claim form. This does not apply to Medicaid recipients in a Medicaid HMO (e.g., *Options*). The amount billed to Medicaid in Block 24F (Charges) must represent only the recipient's copayment amount for the HMO. Since Medicaid also has a copayment amount for office visits, Medicaid will deduct the Medicaid copayment amount from the HMO copayment amount billed in this block. For example, a Medicaid recipient with an HMO as primary insurance may have a $10 copay for an office visit. Medicaid's copay for the office visit is $1.00. Therefore,

Medicaid's allowance will be $9.00 for this office visit. The remaining $1.00 should be collected from the recipient at the time of the service.

RECONSIDERATION

A physician or hospital may request reconsideration for denied hospital days within a 30-day time limit from the date of the original denial. A request for reconsideration of denied hospital days must be accompanied by additional supporting documentation from the certifying physician. A review of additional documentation may sustain the original determination or result in an approval or denial of additional days. Requests received without additional documentation or after the 30-day limit will not be considered.

SUBMISSION OF CLAIMS FOR NONRESIDENT ALIENS

Chapters I and III contain information on the coverage and eligibility requirements for nonresident aliens. To submit a claim for covered emergency services for a nonresident alien:

- Complete the appropriate Medicaid billing form (and any other required forms) in the usual manner.
- Attach a copy of the completed Emergency Medical Certification Form to the invoice. Other relevant documentation to justify the approval has already been submitted and reviewed and; therefore, does not need to be duplicated with this claim.
- Submit the claim using the preprinted envelopes supplied by Medicaid or by mailing the claim directly to the appropriate post office box.

NOTE: The same procedures apply for adjusted or voided claims.

All claims for nonresident aliens will pend for certification to verify that they were related to the emergency situation which has been approved. All claims not related to the emergency treatment will be denied. The documentation for a denied claim will be kept by Medicaid for 180 days from the date of receipt to allow for the appeal process for those services which are not approved.

CLIENT APPEALS OF THE DENIAL OF SERVICES

Any denial of a service decision made by Medicaid staff may be appealed to the Department of Medical Assistance Services. This decision should be appealed in writing by the client or his or her legally appointed representative. All appeals must be filed within 30 days of the date of the final decision notification. Direct appeals to:

Director, Division of Client Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

EXHIBITS

TABLE OF CONTENTS

Disability Evaluation Under Social Security (SSA Publication 64-039) Part III, § 9.09

9.09 Obesity. Weight equal to or greater than the values specified in Table I for males, Table II for females (100 percent above desired level), and one of the following:

A. History of pain and limitation of motion in any weight-bearing joint or the lumbosacral spine (on physical examination) associated with findings on medically acceptable techniques of arthritis in the affected joint or lumbosacral spine; or

B. Hypertension with diastolic blood pressure persistently in excess of 100 mm. Hg measured with appropriate size cuff; or

C. History of congestive heart failure manifested by past evidence of vascular congestion such as hepatomegaly, peripheral or pulmonary edema; or

D. Chronic venous insufficiency with superficial varicosities in a lower extremity with pain on weight bearing and persistent edema; or

E. Respiratory disease with total force vital capacity equal to or less than 2.0 L. or a level of hypoxemia at rest equal to or less than the values specified in Table-III A or III-B or III-C.

DISABILITY CRITERIA FOR THE COVERAGE OF ANOREXIANT DRUGS FOR OBESITY

PART I

Table I - Men
(metric)

Height without shoes (centimeters)	Weight (kilograms)
152	112
155	115
157	117
160	120
163	123
165	125
168	129
170	134
173	137
175	141
178	145
180	149
183	153
185	157
188	162
190	165
193	170

Table II - Women
(metric)

Height without shoes (centimeters)	Weight (kilograms)
142	95
145	96
147	99
150	102
152	105
155	107
157	110
160	114
163	117
165	121
168	125
170	128
173	132
175	135
178	139
180	143
183	146

Table I - Men

Height without shoes (inches)	Weight (pounds)
60	246
61	252
62	258
63	264
64	270
65	276
66	284
67	294
68	302
69	310
70	318
71	328
72	336
73	346
74	356
75	364
76	374

Table II - Women

Height without shoes (inches)	Weight (pounds)
56	208
57	212
58	218
59	224
60	230
61	236
62	242
63	250
64	258
65	266
66	274
67	282
68	290
69	298
70	306
71	314
72	322

DISABILITY CRITERIA FOR THE COVERAGE OF ANOREXIANT DRUGS FOR OBESITY

PART II

Table III – A
(Applicable at test sites less than 3000 above sea level)

Arterial PCO2 (mm.Hg.) and	Arterial PO2 Equal to or less than (mm.Hg.)
30 or below	65
31	64
32	63
33	62
34	61
35	60
36	59
37	58
38	57
39	56
40 or above	55

Table III – B
(Applicable at test sites 3000 through 6000 feet above sea level)

Arterial PCO2 (mm.Hg.) and	Arterial PO2 Equal to or less less than(mm.Hg.)
30 or below	60
31	59
32	58
33	57
34	56
35	55
36	54
37	53
38	52
39	51
40 or above	50

Table III – C
(Applicable at test sites over 6000 feet above sea level)

Arterial PCO2 (mm.Hg.) and	Arterial PO2 (Equal to or less than (mm.Hg.)
30 or below	55
31	54
32	53
33	52
34	51
35	50
36	49
37	48
38	47
39	46
40 or above	45

CASE EXAMPLE: MARY NEEDY

Mary Needy is a 42-year-old insulin dependent diabetic who has a right leg below the knee amputation. In June, 1998, she injured her left knee in a fall that resulted in a puncture wound, and she eventually developed osteomyelitis in the knee joint. After attempting to treat her on oral medication without success, her physician admitted her to the hospital, and on June 5, 1998, he sent her home from the hospital with a Hickman line in place. She was to receive two IV medications: Keflin 250mg q 4 hours and Vancomycin 250mg q 12 hours. On June 8, 1998, the recipient developed a rash, and the Keflin was discontinued. On June 14, 1998, the recipient became dehydrated due to nausea and vomiting from a virus and was started on hydration therapy for two days to correct this problem. Hydration therapy was discontinued on 6/15/98 at 8 p.m. The recipient remained on Vancomycin until July 5, 1998, when laboratory values determined that the infection had resolved**.**

Billing by the DME provider: The recipient received DME Drug Therapy from 6/5/98 to 7/5/98 for a total of 31 days (only one service day rate for each of the days she received two antibiotics). The recipient received DME Hydration Therapy from 6/14/98 to 6/15/98 for a total of two days. Therefore, the DME provider may bill the full service day rate for DME Drug Therapy for 29 days (6/5/98 through 6/13/98 and 6/16/98 through 7/5/98). For the two days of multiple therapies (Drug and Hydration Therapy on June 14-June 15, 1998), the provider may bill the full DME Drug Therapy service day rate and 50% of the DME Hydration Therapy service day rate for each of the 2 days.

Billing by the pharmacy provider: The pharmacy provider may bill for a total of 31 days of Pharmacy Drug Therapy and two days of Pharmacy Hydration Therapy at 100% reimbursement for each day of service. The individual antibiotics/active ingredients are billed separately at the Medicaid allowable cost.

I.V. THERAPY IMPLEMENTATION FORM (DMAS-354)

I.V. THERAPY IMPLEMENTATION FORM

SECTION I:

Recipient Name	
Recipient Medicaid Number	
Physician Name	
Type of Therapy	
Primary Diagnosis	
Secondary Diagnosis	
Recipient History (as relates to I.V. therapy)	
Therapy Start Date	
Anticipated Therapy End Date	
Route of Administration (type of line and device)	

SECTION II:

MEDICATION	DOSAGE	FREQUENCY	DURATION	START DATE	END DATE

SECTION III:
For TPN ONLY USUAL BODY WEIGHT---------
CURRENT BODY WEIGHT------

Diagnosis related to GI dysfunction:	
Dietary consultation: yes no	
Enteral Nutrition attempted: yes no	

SECTION IV:
Physician Signature:_____**Date:**_____

SECTION V:
Actual End Date of Therapy:_____

Physician Signature:_____**Date:**_____

*Note: A new form must be filled out for each new drug added and each new therapy initiated.

DMAS-354

PRACTITIONER REFERRAL FORM

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
CLIENT MEDICAL MANAGEMENT PROGRAM

PRACTITIONER REFERRAL FORM

Recipient's Name: _____ DMAS#: _____

Referred to: _____ Date: _____

Purpose of Referral (check one):

_____ Physician covering in absence of primary health care provider for (specify period of absence for up to 90 days) _____

_____

_____ See one time only for _____

_____ See as needed for on-going treatment of _____

_____

(Referral for on-going treatment must be renewed at 90 day intervals.)

This recipient is restricted to me as his/her primary health care provider. Please refer to the billing chapter in your Medicaid Provider Manual for billing information. **This form must be part of your medical record. For reimbursement, a copy must be attached to every claim submitted on behalf of this recipient.**

If you wish to refer this patient to another source who will be billing Medicaid, you must obtain another referral form for that physician from me.

These referral provisions do not apply while the recipient is an inpatient in a hospital.

_____
Signature of Primary Health Care Provider

_____
Name of Primary Health Care Provider

Provider ID#: _____

Address: _____

_____

_____

Telephone #: (_____) _____

(Instructions on Back)

DMAS-70 4/89

REFERRAL PHYSICIAN'S COPY

MATERNITY RISK SCREEN

MATERNITY RISK SCREEN

Research supports the fact that indigent high risk pregnant women and mothers of high risk infants often need a combination of medical and non-medical services to ensure a positive pregnancy outcome and infant health.

The risk screen is designed to capture high risk pregnant women as identified by the BabyCare Program. Risk must not be altered. Please check all risks that apply to the recipient and make the appropriate referral(s).

PATIENT NAME: _____ VMAP ID# _____ EXPECTED DELIVERY DATE: _____

PREGNANCY CONDITIONS:

A. MEDICAL

- |__| Hypertension: chronic or pregnancy induced.
- |__| Gestational diabetes/diabetes
- |__| Multiple gestation (e.g. twins, triplets)
- |__| Previous preterm birth or low weight birth (5 lbs or less)
- |__| Advanced maternal age (older than 35 years)
- |__| Medical condition (s), the severity of which affects their obstetrical condition and requires treatment by another medical provider and requires care coordination. (Document medical condition below.)
- |__| Previous fetal death

Client's drug use:

- |__| Alcohol
- |__| Cocaine/crack
- |__| Narcotics/heroine/codeine/morphine
- |__| Marijuana/hashish
- |__| Over-the-counter drugs
- |__| Sedatives/tranquilizers
- |__| Amphetamines/speed/diet pills
- |__| Prescription drugs
- |__| Inhalants/glues/solvents
- |__| Tobacco/cigarettes

B. SOCIAL

- |__| Teenager 18 years or younger
- |__| Non compliant with medical directions or keeping medical appointments
- |__| Mental retardation or history of emotional/mental problems
- |__| Abuse/neglect during pregnancy
- |__| Shelter, homeless or migrant worker

C. NUTRITION

- |__| Prepregnancy underweight/overweight, inadequate weight gain or excessive weight gain.
- |__| Obstetrical or medical conditions such as multiple gestation, delayed uterine growth, anemia, diabetes, hypertension or other conditions requiring diet modification.
- |__| Poor diet or pica

REFERRAL:

|__| Care Coordination |__| Nutritional Counseling |__| Homemaker |__| Patient Education

|__| No care coordination - what services will recipient receive? _____

PROVIDER COMMENTS, SUGGESTIONS OR INSTRUCTIONS: _____

_____

_____

SIGNATURE/TITLE _____ SCREENING DATE: _____

SIGNATURE PRINTED _____ PROVIDER #: _____

Revised 03/02 WPPSMRC #655

INFANT RISK SCREEN

INFANT RISK SCREEN

Research supports the fact that indigent mothers and their high risk infants often need a combination of medical and non-medical services to assure positive infant health.

The risk screen is designed to capture high risk infants as identified by the BabyCare Program. Risks must not be altered. Please check all risks that apply to the recipient and make the appropriate referral.

PATIENT NAME: _____ VHAP ID# _____

PARENT/GUARDIAN NAME: _____

A. MEDICAL

- ☐ Diagnosed developmentally delayed/neurologically impaired
- ☐ Diagnosed medically significant genetic condition (including sickle cell disease)
- ☐ Birth weight 1750 grams (3 lbs., 14 oz.) or less
- ☐ Chronic illness
- ☐ Diagnosed with fetal alcohol syndrome (FAS)
- ☐ Medical high risk infant and pediatric care needed, but not available 24 hours a day
- ☐ Medical conditions which require consultation or treatment by another medical provider and requiring care coordination (document medical condition below)
- ☐ Born exposed to an illegal drug in utero

B. SOCIAL

- ☐ Parent/guardian unable to communicate due to language barriers (e.g. non-English speaking, illiterate)
- ☐ Maternal absence (illness, incarceration, abandonment)
- ☐ Parental substance abuse/addiction (only includes father if living in home)
- ☐ Caregiver's handicap presents risk to infant (physically impaired, hearing impaired, vision impaired)
- ☐ Caregiver mental illness/mental retardation
- ☐ Shelter, homeless or migrant worker
- ☐ Mother 18 years or younger
- ☐ History of suspected abuse and/or neglect
- ☐ Non compliant with follow-up visits/screening visits and medical direction for <u>this infant</u>.

C. NUTRITION

- ☐ Congenital abnormalities affecting ability to feed or requiring special feeding techniques; poor sucking, severe or continuing diarrhea or vomiting; other conditions requiring diet modification
- ☐ Failure to thrive or flattening of growth curve
- ☐ Inappropriate diet resulting from maternal lack of knowledge in feeding this infant.

REFERRAL: ☐ Care Coordination

☐ No Care Coordination - What services will the recipient receive? _____

PROVIDER COMMENTS, SUGGESTIONS, OR INSTRUCTIONS: _____

_____

_____

SIGNATURE/TITLE _____ SCREENING DATE _____

SIGNATURE PRINTED _____ PROVIDER I.D. # _____

ABORTION CERTIFICATION (DMAS-3006)

VIRGINIA MEDICAL ASSISTANCE PROGRAM

ABORTION CERTIFICATION

I, Doctor _____,

certify that on the basis of my professional judgment ☐ the life ☐ the health of

_____ of _____
(Name) (Address)

would be substantially endangered if the fetus was carried to term.

This judgment is based on the following diagnoses and/or conditions:

_____

_____

_____

_____

_____

_____

_____

_____
(Signature)

_____
(Address)

_____

MAP - 3006

PHYSICIAN COPY

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION FORM (DMAS-3005)

VIRGINIA MEDICAL ASSISTANCE PROGRAM

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

PATIENT ACKNOWLEDGMENT

Recipient Eligibility Number: _____

It has been explained to _____ of
(Recipient's Name)

_____, _____, _____
(Address) (City & State) (Zip Code)

that the hysterectomy to be performed on her will render her permanently incapable of reproducing.

_____ _____
(Recipient's or Representative's Signature) (Date)

If Required: _____ _____
(Interpreter's Signature) (Date)

PHYSICIAN STATEMENT

I, Doctor _____, certify that the hysterectomy

performed _____ on _____ of
(Date of Operation) (Recipient's Name)

_____, _____, _____
(Address) (City & State) (Zip Code)

(X) MARK THE APPROPRIATE BLOCK

A ☐ was not performed solely for the purpose of rendering the above mentioned recipient permanently incapable of reproducing nor was the hysterectomy done for medical purposes which by themselves do not mandate a hysterectomy.

B ☐ was performed under a life-threatening emergency situation which precluded explaining to her that the hysterectomy to be performed would render her permanently incapable of reproducing and obtaining an Acknowledgment of Receipt of Hysterectomy Information. The life-threatening emergency situation was

_____

_____
(A Description of the Nature of the Emergency)

C ☐ was performed subsequent to the patient being sterile. This judgment is based on the following condition(s): _____

_____

_____ _____
(Physician's Signature) (Date)

(A COPY OF THE COMPLETED CERTIFICATION MUST BE ATTACHED TO EACH INVOICE FOR A HYSTERECTOMY PROCEDURE. THE SURGEON MUST PROVIDE COPIES TO OTHER PROVIDERS FOR THEIR USE WHEN BILLING MEDICAID.)

MAP-3005 R 8/84

PHYSICIAN COPY

STERILIZATION CONSENT FORM (DMAS-3004)

VIRGINIA MEDICAL ASSISTANCE PROGRAM

STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ (Month Day Year)

I, _____, hereby consent of my own free will to be sterilized by _____ (doctor) by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human services or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date _____
Signature (Month Day Year)

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Island
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ _____
Interpreter (Signature) *Date*

DMAS - 3004 R 8/84

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____ _____
Signature of person obtaining consent *Date*

_____
Facility

_____
Address

■ PHYSICIAN'S STATEMENT ■

(TO BE COMPLETED FOLLOWING SURGERY)

Shortly before I performed a sterilization operation upon _____ (Name of individual to be sterilized) on _____ (Date of sterilization). I explained to him/her the nature of the operation sterilization operation _____ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

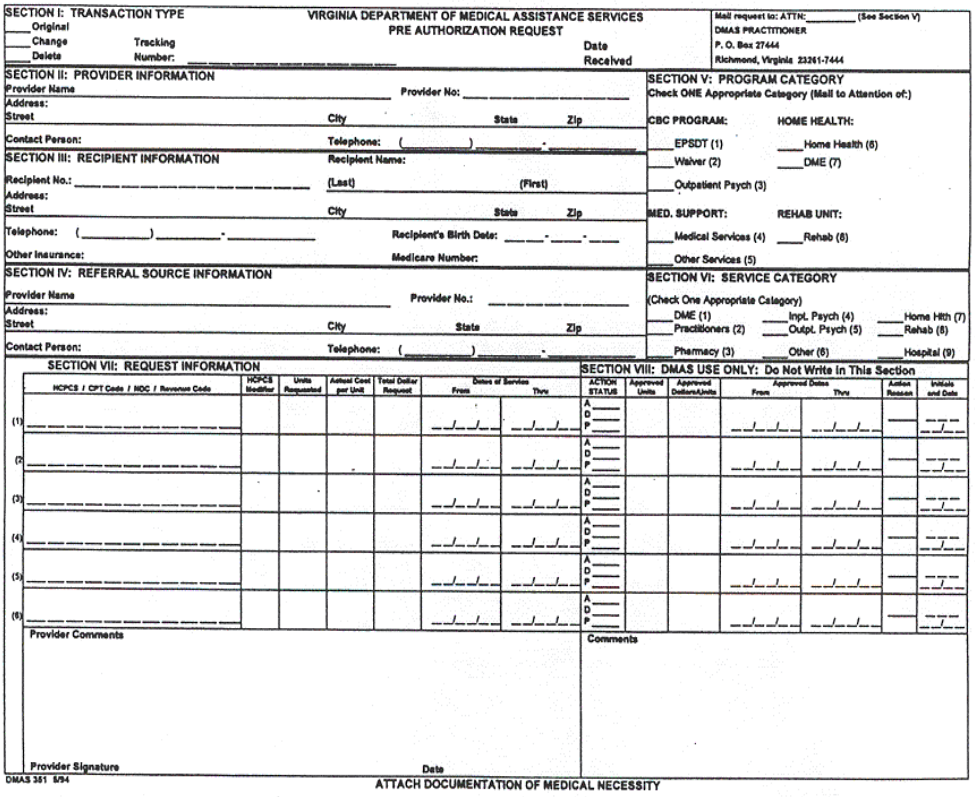
- ☐ Premature delivery
  Individual's expected date of delivery: _____ (Date)
- ☐ Emergency abdominal surgery:
  (describe circumstances): _____

_____ _____
(Signature) *Physician*
Date _____

ALL APPLICABLE BLANKS MUST BE COMPLETED.
STAMPED SIGNATURES ARE NOT ACCEPTABLE.

PHYSICIAN COPY

DMAS-351 PRE AUTHORIZATION REQUEST FORM



SECTION I: TRANSACTION TYPE
___Original
___Change
___Delete
Tracking Number: _____

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PRE AUTHORIZATION REQUEST
Date Received

Mail request to: ATTN: _____ (See Section V)
DMAS PRACTITIONER
P. O. Box 27444
Richmond, Virginia 23261-7444

SECTION II: PROVIDER INFORMATION
Provider Name _____ Provider No: _____
Address:
Street _____ City _____ State _____ Zip _____
Contact Person: _____ Telephone: (_____) _____-_____

SECTION III: RECIPIENT INFORMATION
Recipient Name:
Recipient No.: _____ (Last) _____ (First) _____
Address:
Street _____ City _____ State _____ Zip _____
Telephone: (_____) _____-_____ Recipient's Birth Date: ____-____-____
Other Insurance: _____ Medicare Number: _____

SECTION IV: REFERRAL SOURCE INFORMATION
Provider Name _____ Provider No.: _____
Address:
Street _____ City _____ State _____ Zip _____
Contact Person: _____ Telephone: (_____) _____-_____

SECTION V: PROGRAM CATEGORY
Check ONE Appropriate Category (Mail to Attention of:)

CBC PROGRAM:
___EPSDT (1)
___Waiver (2)
___Outpatient Psych (3)

HOME HEALTH:
___Home Health (6)
___DME (7)

MED. SUPPORT:
___Medical Services (4)
___Other Services (5)

REHAB UNIT:
___Rehab (8)

SECTION VI: SERVICE CATEGORY
(Check One Appropriate Category)
___DME (1)
___Practitioners (2)
___Pharmacy (3)
___Inpt. Psych (4)
___Outpt. Psych (5)
___Other (6)
___Home Hlth (7)
___Rehab (8)
___Hospital (9)

SECTION VII: REQUEST INFORMATION

	HCPCS / CPT Code / NDC / Revenue Code	HCPCS Modifier	Units Requested	Actual Cost per Unit	Total Dollar Request	Dates of Service From	Dates of Service Thru
(1)						__/__/__	__/__/__
(2)						__/__/__	__/__/__
(3)						__/__/__	__/__/__
(4)						__/__/__	__/__/__
(5)						__/__/__	__/__/__
(6)						__/__/__	__/__/__

SECTION VIII: DMAS USE ONLY: Do Not Write In This Section

	ACTION STATUS	Approved Units	Approved Dollars/Units	Approved Dates From	Approved Dates Thru	Action Reason	Initials and Date
(1)	A ___ D ___ P ___			__/__/__	__/__/__	___	__/__/__
(2)	A ___ D ___ P ___			__/__/__	__/__/__	___	__/__/__
(3)	A ___ D ___ P ___			__/__/__	__/__/__	___	__/__/__
(4)	A ___ D ___ P ___			__/__/__	__/__/__	___	__/__/__
(5)	A ___ D ___ P ___			__/__/__	__/__/__	___	__/__/__
(6)	A ___ D ___ P ___			__/__/__	__/__/__	___	__/__/__

Provider Comments

Comments

Provider Signature _____ Date _____

DMAS 351 5/94

ATTACH DOCUMENTATION OF MEDICAL NECESSITY

DMAS-352 CERTIFICATION OF MEDICAL NECESITY FORM

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
CERTIFICATE OF MEDICAL NECESSITY
DURABLE MEDICAL EQUIPMENT AND SUPPLIES

SECTION I RECIPIENT DATA / SERVICING PROVIDER / CMN STATUS

I.D. #		I.D. #	
Name		Name	☐ INITIAL
D.O.B.		Contact Person	☐ REVISED
Phone #	( )	Phone #	( ) ☐ RENEWED

SECTION II RECIPIENT INFORMATION

Answer all questions that are applicable to DME service being requested. If answer is yes, you must describe/attach additional information.

DESCRIPTION/ADDITIONAL INFORMATION: (Additional space on reverse)

Does patient:	YES	NO
1. have impaired mobility?	☐	☐
2. have impaired endurance?	☐	☐
3. have restricted activity?	☐	☐
4. have skin breakdown? (Describe site, size, depth and drainage)	☐	☐
5. have impaired respiration? (Identify most recent PO_2_____/Saturation level _____ for patients on oxygen)	☐	☐
6. require assistance with ADL's?	☐	☐
7. have impaired speech?	☐	☐
8. require nutritional supplements? (Identify complete diet order)	☐	☐

IS THE ITEM SUITABLE FOR USE IN HOME, AND DOES THE PATIENT/CAREGIVER DEMONSTRATE WILLINGNESS/ABILITY TO USE THE EQUIPMENT? YES____NO____

DATE PATIENT LAST EXAMINED BY PHYSICIAN _____

ICD9 Code	Clinical Diagnoses	Date of Onset: Less than 6 months	Date of Onset: Greater than 6 months

SECTION III (ADDITIONAL SPACE ON REVERSE)

Begin Service Date	HCPCS Code	Item Ordered Description	Length of Time Needed	Quantity Ordered/ x1 Month	Quantity/Frequency of Use Justification/Comments

SECTION IV PHYSICIAN CERTIFICATION (MUST BE SIGNED AND DATED BY PHYSICIAN)

I CERTIFY THAT THE ORDERED DME AND SUPPLIES ARE PART OF MY TREATMENT PLAN AND, IN MY OPINION, ARE MEDICALLY NECESSARY.

ORDERING PHYSICIAN'S NAME (print) _____ PHYSICIAN'S SIGNATURE _____ DATE _____ I.D.# _____ ( ) PHONE # _____

DMAS-352, Revised 8/95

DMAS-352 CERTIFICATE OF MEDICAL NECESSITY

RECIPIENT NAME		VMAP #	
SERVICING PROVIDER NAME		PROVIDER ID#	

DESCRIPTION/ADDITIONAL INFORMATION

SECTION II (continued)

SECTION III (continued)

Begin Service Date	HCPCS Code	Item Ordered Description	Length of Time Needed	Quantity Ordered/ x1 Month	Quantity/Frequency of Use Justification/Comments

SECTION IV PHYSICIAN CERTIFICATION (MUST BE SIGNED AND DATED BY PHYSICIAN)

I CERTIFY THAT THE ORDERED DME AND SUPPLIES ARE PART OF MY TREATMENT PLAN AND, IN MY OPINION, ARE MEDICALLY NECESSARY.

ORDERING PHYSICIAN'S NAME (print) | PHYSICIAN'S SIGNATURE | DATE | I.D.# | ( ) PHONE #

Section I RECIPIENT DATA

- Complete 12-digit recipient identification number
- Complete recipient full name (last name, first name)
- Complete full date of birth (month, day, year)
- Telephone # (include area code)

SERVICING PROVIDER

- Complete provider number (7-digits)
- Complete provider name
- Complete contact identifying person to call if DMAS has questions

CMN STATUS

- Check appropriate box

Section II RECIPIENT INFORMATION

- Check ALL boxes that apply
- Identify functional limitations related to recipient and need for DME service
- If requesting oxygen, the results of PO_2/Saturation levels must be identified
- Date last examined by physician
- ICD9 Code (optional)
- Clinical diagnoses - narrative must be identified. Diagnosis must be related to the item being requested
- Check appropriate line for date of on-set

Section III

- Begin service date (month, day and year)
- Item ordered description: must be narrative description of item ordered (DME vendor may identify by HCPC Code)
- Length of Time Needed: length of time item will be needed for all durable equipment
- Quantity ordered: identify quantity ordered; for expendable supplies, designate supplies needed for 1 month; if items are required greater than 1 month, note time frame in the Length of Time Needed column
- Quantity/Frequency of Use, Justification/Comments: physician's order for frequency of use must be identified

Section IV PHYSICIAN CERTIFICATION

- Physician full name (print)
- *Must* be signed and fully dated by physician (NOTE: Attached physician prescription will ***not*** be accepted in lieu of physician signature/date on this form); IF ORDERS FOR DME SERVICE ARE WRITTEN ON BOTH SIDES OF FORM, PHYSICIAN ***MUST*** SIGN/DATE *BOTH* SIDES OF FORM
- Complete physician Medicaid provider number (optional)
- Telephone number (include area code)

DMAS-352, Revised 8/95

Diagnosis To Be Paid At Emergency Rate
By ICD-9-CM Code
Effective Revision Date 01/01/03

00100-00190	Cholera
00200-00290	Typhoid, Paratyphoid Fever
00300-00390	Salmonella Infections
00400-00490	Shigellosis
00500-00590	Other Food Poisoning (bacterial)
00600-00690	Amebiasis
00700-00790	Other Protozoal Diseases
00800-00809	Intestinal Infection due to Other Organisms
0081	Arizon Group of Paracolon Bacilli
0082	Aerobacter Aerogenes
0083	Proteus (mirabilis) (morganii)
00840-00850	Other Specified Bacteria
00860-00869	Enteritis due to Specified Virus
0088	Other Organism, not elsewhere classified
00900-00930	Ill Defined Intestinal Infections
01000-01896	Tuberculosis
02000-02090	Plague
02100-02190	Tularemia
02200-02290	Anthrax
02300-02390	Brucellosis
02400-02500	Glanders, Melioidosis
02600-02690	Rat Bite Fever
02700-02790	Other Zoonotic Bacterial Diseases
03000-03090	Leprosy
03100-03190	Diseases due to Other Mycrobacteria
03200-03290	Diphtheria
03300-03390	Whooping Cough
03440-03410	Streptococcal Sore Throat and Scarlett Fever
035	Erysipelas
03600-03690	Meningococcal Meningitis, Encephalitis, Carditis
037	Tetanus
038	Septicemia
03900-03990	Actinomycotic Infections
04000-04030	Other Bacterial Diseases
04081-04089	Tropical Pyomyosistis; Other Bacterial disease-toxic shock syndrome
04500-04593	Acute Poliomyelitis
04700-04790	Meningitis due to Enterovirus
048	Other Enterovirus of CNS
04900-04990	Non-Arthropod Virus of CNS, Encephalitis, Meningitis
05000-05090	Smallpox
05200-05290	Chickenpox
05300-05390	Herpes Zoster

Diagnosis To Be Paid At Emergency Rate
By ICD-9-CM Code
Effective Revision Date 01/01/03

05410-05490	Herpes Simplex
05500-05510	Post Measles Encephalitis or Pneumonia
05571	Measles Keratoconjunctivitis
05600-05690	Rubella with Neurological and Other Specified Complications
06000-06090	Yellow Fever
061	Dengue
06200-06290	Mosquito-Borne Viral Encephalitis
06300-06390	Tick-Borne Encephalitis
064	Viral Encephalitis by Arthropod
06500-06590	Arthropod-Borne Hemorrhagic Fever
06600-06680	Other Arthropod-Borne Viral Diseases
07000-07060	Viral Hepatits
07100-07101	Rabies
07200-07290	Mumps
07300-07390	Ornithosis
07400-07423	Coxsackie
0774	Epidemic Hemorrhagic Conjunctivitis
07860-07861	Hemorrhagic Nephrosonephritis
07870-07871	Arenaviral Hemorrhagic Fever
0796	Respiratory Syncytial Virus (RSV)
08000-08190	Typhus Fever
08200-08290	Tick-Borne Rickettsioses
08300-08390	Other Rickettsioses
08400-08490	Malaria
08500-08590	Leishmaniasis
08600-08690	Trypanosomiasis
08700-08790	Relapsing Fever
08800-08890	Other Arthropod-Borne Diseases
09000-09790	Syphillis
0980	Gonococcal Infections
09810-09819	Acute, of Upper Genitourinary Tract
09840-09889	Gonococcal Infections of Eye, Joint, or Other Specified Sites
09900-09930	Other Venereal Diseases
09940-09949	Other Nongonococcal Uretritis
09950-09990	Other Veneral Disease related to Chlamydia Trachomatis
1000-10081	Leptospirosis
1124	Candidal Pneumonia
11281-11285	Candidal Endocarditis
1142	Coccidioidal Meningitis
11501-11505	Histoplasmosis with Meningitis, Retinitis, Pericarditis, Pneumonia
11511-11515	Infection by Histoplasma Duboisii
11591-11595	Histoplasmosis, unspecified
13000-13090	Toxoplasmosis

13630-13630	Pneumocystosis
24200-24291	Thyrotoxicosis
2450	Acute Thyroiditis
2463	Hemorrhage, Infarct of Thyroid
25002	Diabetes Mellitus without mention of complication, Type I, uncontrolled
25003	Diabetes Mellitus without mention of complication, Type II, uncontrolled
25010-25033	Diabetes with Ketoacidosis; Hyperosmolality; or Coma
25042-25043	Diabetes with Renal Manifestations; Type I or II; uncontrolled
25052-25053	Diabetes with Ophthalmic Manifestations; Type I or II; uncontrolled
25062-25063	Diabetes with Neurological Manifestations; Type I or II; uncontrolled
25072-25073	Diabetes with Peripheral Circulatory Disturbances; Type I or II; uncontrolled
25082-25083	Diabetes with Other Specified Manifestations; Type I or II; uncontrolled
25092-25093	Diabetes with Unspecified Complications; Type I or II; uncontrolled
25100-25120	Hypoglycemia
2521	Hypoparathyroidism (parathyroiditis, tetany)
2535	Diabetes Insipidus
2554	Corticoadrenal Insufficient; Addisonian Crisis
262	Other Severe, Protein-Calorie Malnutrition
2740	Gouty Arthropathy
27541	Hypocalcemia
27542	Hypercalcemia
27600-27680	Disorders of Fluid, Electrolyte, and Acid-base Balance
28262	Sickle Cell Crisis
28311	Hemolytic-uremic Syndrome
2851	Acute Post Hemorrhagic Anemia
28600-28790	Coagulation Defects; Other Hemorrhagic Conditions
29011	Presenile Dementia with Delirium
2903	Senile Dementia with Delirium
29041	Arteriosclerotic Dementia with Delirium
2910	Alcohol Withdrawal Delirium
2913	Alcohol Withdrawal Hallucinosis
29181	Alcohol Withdrawal
29212	Drug Induced Hallucinosis
29281	Drug Induced Delirium
2930	Transient Organic Psychotic Condition- acute delirium
29503-29504	Schizophrenic Disorder, Simple Type, with Acute Exacerbation
29513-29514	Schizophrenic Disorder, Disorganized Type, with Acute

	Exacerbation
29523-29524	Schizophrenic Disorder, Catatonic Type, with Acute Exacerbation
29533-29534	Schizophrenic Disorder, Paranoid Type, with Acute Exacerbation
29543-29544	Acute Schizophrenic Episode
29553-29554	Latent Schizophrenia, with Acute Exacerbation
29563-29564	Residual Schizophrenia, with Acute Exaceration
29573-29574	Schizophrenic Disorder, Schizo-Affective Type, with Acute Exacerbation
29583-29584	Other Specified Types of Schizophrenia, with Acute Exacerbation
29593-29594	Unspecified Schizophrenic, with Acute Exacerbation
29603-29604	Affective Psychoses, Manic Disorder, single episode
29613-29614	Affective Psychoses, Manic Disorder, recurrent episode
29623-29624	Affective Psychoses, Major Depression, single episode
29633-29634	Affective Psychoses, Major Depression, recurrent episode
29643-29644	Affective Psychoses, Bipolar Affective Disorder, Manic
29653-29654	Affective Psychoses, Bipolar Affective Disorder, Depressed
29663-29664	Affective Psychoses, Bipolar Affective Disorder, Mixed
32000-32299	Meningitis
32300-32390	Encephalitis, Myelitis, and Encephalomyelitis
32400-32490	Intracranial and Intraspinal Abscess
325	Phlebitis and Thrombophlebitis of Intracranial Venous Sinuses
32600-32690	Late Effects of Intracranial Abscess or Pyrogenic Infection
33383	Spasmodic Torticollis
33392	Neuroleptic Malignant Syndrome
3343	Other Cerebellar Ataxia
3361	Vascular Myelopathies; Acute Infarct of Spinal Cord
34511	Convulsive Epilepsy, Intractable
34520-34530	Petit Mal and Grand Mal Status
34540-34541	Partial Epilepsy, with Impairment of Consciousness
34561	Infantile Spasms, with Intractable Epilepsy
34571	Epilepsia Partilis Continuous with Intractable Epilepsy
34581	Other Forms of Epilepsy with Intractable Epilepsy
34591	Epilepsy, Unspecified, with Intractable Epilepsy
34601	Classical Migraine, with Intractable Migraine, so stated
34611	Common Migraine, with Intractable Migraine, so stated
34621	Variants of Migraine, with Intractable Migraine, so stated
34681	Other Forms of Migraine, with Intractable Migraine, so stated
34691	Migraine, Unspecified with Intractable Migraine
3481	Anoxic Brain Damage
34830-34840	Encephalopathy; Compression of Brain
3485	Cerebral Edema
3490	Reaction to Spinal or Lumbar Puncture

3491	Nervous System Reaction from Surgically Implanted Device
34981	Cerebrospinal Fluid Rhinorrhea
34982	Toxic Encephalopathy
3501	Trigeminal Neuralgia
3510	Bell's Palsy
3570	Acute Infective Polyneuritis
3580	Myasthenia Gravis
36000-36019	Purulent and Other Endophthalmitis
36100-36105	Retinal Detachment with Retinal Defect
3612	Serous Retinal Detachment
36181-36190	Other Forms of Retinal Detachment
36230-36243	Retinal Vasular Occlusion or Separation Retinal Layers
36281	Retinal Hemorrhage
36361-36363	Choroidal Hemorrhage or Rupture
36370-36372	Choroidal Detachment or Hemorrhage
36400-36405	Acute and Subacute Iridocyclitis
36421-36441	Certain Types of Iridocyclitis
36504	Ocular Hypertension
36522	Acute Angle-Closure Glaucoma
36565	Glaumoma Associated with Ocular Trauma
36811-36812	Sudden or Transient Vision Loss
37000	Corneal Ulcer, unspecified
37003	Central Corneal Ulcer
37006	Perforated Corneal Ulcer
37020-37024	Superficial Keratitis without Conjunctivitis
37040	Keratoconjunctivitis, unspecified
37044	Keratitis or Keratoconjunctivitis in Exanthema
37050-37059	Interstitial and Deep Keratitis, including Corneal Abscess
37120-37124	Corneal Edema
37200-37202	Acute Conjunctivitis
37205	Acute Atopic Conjunctivitis
37220-37222	Blepharoconjunctivitis
37233	Conjunctivitis in Mucocutaneous Disease
37271-37273	Hyperemia of Conjunctiva, Conjunctival Hemorrhage or Edema
37301-37302	Blepharitis, Unspecified, Ulcerative or Squamous
37311-37312	Hordeolum Externum or Internum
37313	Abscess of Eyelid
37481	Hemorrhage of Eyelid
37486	Retained Foreign Body of Eyelid
37500-37501	Dacryadenitis, acute or unspecified
37530-37533	Acute and Unspecified Inflammation of Lacrimal System
37600-37604	Acute Inflammation of Orbit
37632-37636	Orbital Hemorrhage, Edema, Congestion or Intermittent, Pulsating Exophthalmos

37701	Papilledema, Unspecified or Associated with Intracranial Pressure
37732	Retrobulbar Neuritis (acute)
37741-37749	Other Disorders of Optic Nerve
37851-37854	Paralytic Strabismus
37923	Vitreous Hemorrhage
37926	Vitreous Prolapse
37932-37934	Subluxation; Anterior or Posterior Dislocation of Lens
38001	Acute Perichondritis of Pinna
38010-38014	Infective Otitis Externa
38022	Other Acute Otitis Externa
38031	Hematoma of Auricle or Pinna
38200-38202	Acute Suppurative Otitis Media, with or without Spontaneous Rupture of Ear Drum, or with Diseases classified elsewhere
38300-38302	Acute Mastoiditis; Subperiosteal Abscess of Mastoid; Acute Mastoiditis with other complications
38400-38401	Acute Myringitis, Bullous or unspecified
38420-38425	Perforation of Tympanic Membrane
38583	Retained Foreign Body of Middle Ear
38600-38603	Active Meniere's Disease
38610-38620	Other and Unspecified Peripheral Vertigo
38630-38635	Labrinthitis
38811	Acoustic Trauma (explosive) to Ear
38812	Noise Induced Hearing Loss
3882	Sudden Hearing Loss, Unspecified
38861	Spinal Fluid Otorrhea
38870-38871	Otalgia, Unspecified or Otogenic Pain
39100-39190	Rheumatic Fever with Heart Complications
39891	Rheumatic Heart Failure (congestive)
4010	Malignant Hypertension
40200-40201	Hypertensive Heart Disease; Malignant, with or without Congestive Heart Failure
40211	Hypertensive Heart Disease; Benign, with Congestive Heart Failure
40291	Hypertensive Heart Disease; Unspecified, with Congestive Heart Failure
40301	Malignant Hypertensive Renal Disease with Renal Failure
40311	Benign Hypertensive Renal Disease with Renal Failure
40391	Unspecified Hypertensive Renal Disease with Renal Failure
40400-40403	Malignant Hypertensive Heart Disease and Renal Failure with Renal Failure
40411-40413	Benign Hypertensive Heart and Renal Disease
40491-40493	Unspecified Hypertensive Heart and Renal Disease
40501	Malignant Secondary Hypertension, Renovascular

Diagnosis To Be Paid At Emergency Rate
By ICD-9-CM Code
Effective Revision Date 01/01/03

41000-41189	Myocardial Infarction
41300-41390	Angina Pectoris
41410-41411	Aneurysm of Heart
41412	**Aneurysm and Dissection of Heart, Dissection of Coronary Artery**
41500-41519	Acute Cor Pulmonale; Pulmonary Embolism
42000-42099	Acute Pericarditis
42100-42190	Acute and Subacute Endocarditis
42200-42299	Acute Myocarditis
42300-42390	Other Diseases of the Pericardium
42490-42499	Endocarditis, Valve unspecified
42600-42790	Conduction Disorders
42800-**42810**	Heart Failure, specified
42821	**Systolic Heart Failure, Acute**
42823	**Systolic Heart Failure, Acute or Chronic**
42831	**Diastolic Heart Failure, Acute**
42833	**Diastolic Heart Failure, Acute or Chronic**
42841	**Combined Systolic and Diastolic Heart Failure, Acute**
42843	**Combined Systolic and Diastolic Heart Failure, Acute or Chronic**
42890	**Heart Failure, Unspecified**
4290	Myocarditis, unspecified
42940-42940	Functional Disturbances After Cardiac Surgery
42950-42960	Rupture of Chordae Tendineae or Papillary Muscle
42971-42979	Certain Sequelae of Myocardial Infarction, not elsewhere classified
430	Subarachnoid Hemorrhage
431	Intracerebral Hemorrhage; Other and Unspecified Intracranial Hemorrhage
4320	Nontraumatic Extradural Hemorrhage
4321	Subdural Hemorrhage
4329	Unspecified Intracranial Hemorrhage
43300-43491	Occlusion or Stenosis of Cerebral and Precerebral Arteries
43500-43590	Transient Cerebral Ischemia
436	Acute Ill-Defined Cerebrovascular Disease; Stroke
43720-43730	Hypertensive Encephalopathy; Cerebral Aneurysm
4376	Nonpyogenic Thrombosis of Venous Sinus
4377	Transient Global Amnesia
44021-44024	Atherosclerosis of the Extremities; with Claudication, Rest Pain, Ulceration, Gangrene
44100-44290	Aortic and Other Aneurysms
44321-44329	**Dissection of Artery**
44400-44490	Arterial Embolism and Thrombosis

44501-44502	**Anteroembolism**
44581-44589	**Chronic Venous Hypertension**
44600-44610	Polyartertis Nodosa and Allied Conditions
44620-44670	Hypersensitivity Angiitis
44700-44790	Other Disorders of Arteries and Arterioles
45100-45199	Phlebitis and Thrombophlebitis
45200-45201	Portal Vein Thrombosis
45300-45399	Other Venous Embolism and Thrombosis
4560	Esophageal Varices with Bleeding
45620	Esophageal Varices in Diseases classified elsewhere with Bleeding
45700-45720	Postmastectomy Lymphedema Syndrome; Other Lymphedema; Lymphangitis
4580	Orthostatic Hypotension
4582	Istrogenic Hypotension
4588	Other Specified Hypotension
4590	Hemorrhage, Unspecified
46401	Acute Laryngitis with Obstruction
46451	Supraglottis with Obstruction
46411	Acute Layngitis and Tracheitis with Obstruction
46421	Acute Laryngotracheitis with Obstruction
46430-46431	Acute Epiglottitis
4644	Croup
46611-46619	Acute Bronchiolitis
475	Peritonsillar Abscess
47821-47825	Cellulitis, Abscess or Edema of Pharynx; Para or Retropharynx
47830-47834	Paralysis of Vocal Cords or Larynx
4786	Edema of Larynx
47871-47875	Other Diseases of Larynx, not elsewhere classified
48000-48780	Viral, Bacterial, Staphylococcus or Other Pneumonia
49121	Obstructive Chronic Bronchitis with Acute Exacerbation
49301	Extrinsic Asthma with Status Asthmaticus
49302	Extrinsic Asthma with Status Asthmaticus with Acute Exacerbation
49311	Intrinsic Asthma with Status Asthmaticus
49312	Intrinsic Asthma with Status Asthmaticus with Acute Exacerbation
49321	Chronic Obstructive Asthma with Status Asthmaticus
49322	Chronic Obstructive Asthma with Acute Exacerbation
49391-49392	Asthma; Unspecified with Status Asthmaticus or with Acute Exacerbation
4941	Bronchiestasis with Acute Exacerbation
50600-50630	Acute Respiratory Conditions due to Chemical Fumes and

	Vapors
50700-50780	Pneumonitis due to Solids or Liquids
5080	Acute Pulmonary Manifestations due to Radiation
51000-51090	Empyema
51100-51190	Pleurisy
51200-51280	Pneumothorax
51300-51310	Abscess of Lung and Mediastinum
5180	Pulmonary Collapse
51840-51850	Acute Edema of Lung; Pulmonary Insufficiency Following Trauma or Surgery
51881-51882	Acute Respiratory Failure
51900-51909	Tracheostomy Infection and Complications
52511	Loss of Teeth Due to Accident, Extraction, or Local Peridontal Disease
5283	Celluitis and Abscess of Soft Tissues
5300	Achalasia and Cardiospasm
53020-53040	Ulcer, Stricture, Stenosis or Perforation
5307	Gastroesophageal Laceration-Hemorrhage Syndrome
53082	Esophageal Hemorrhage
53084	Tracheoesophagefistula
53100-53161	Gastric Ulcer; with Hemorrhage, Perforation or Obstruction; acute or chronic
53171	Gastric Ulcer; Chronic with Obstruction
53191	Gastric Ulcer; Unspecifieas acute or chronic, with obstruction
53200-53261	Duodenal Ulcer with Hemorrhage, Perforation or Obstruction; acute or chronic
53271	Duodental Ulcer; Chronic with Obstruction
53291	Duodental Ulcer; Unspecified with Obstruction
53300-53361	Peptic Ulcer with Hemorrhage, Perforation or Obstruction; acute or chronic
53371	Peptic Ulcer; Chronic with Obstruction
53391	Peptic Ulcer; Unspecified with Obstruction
53400-53461	Gastrojejunal Ulcer with Hemorrhage, Perforation or Obstruction; acute or chronic
53471	Gastrojejunal Ulcer; Chronic with Obstruction
53491	Gastrojejunal Ulcer; Unspecified with Obstruction
53501	Acute Gastritis with Hemorrhage
53511	Atrophic Gastritis with Hemorrhage
53521	Gastric Mucosal Hypertropy with Hemorrhage
53531	Alcoholic Gastritis with Hemorrhage
53541	Other Specified Gastritis with Hemorrhage
53551	Unspecified Gastritis and Gastroduodenitis with Hemorrhage
53561	Duodenitis with Hemorrhage
5363	Gastroparesis

53640-53690	Gastrostomy Complications or Function of Stomach
5370	Acquired Hypertrophic Pyloric Stenosis
5373	Other Obstruction of Duodenum
5374	Fistula of Stomach or Duodenum
53783	Angiodyplasia of Stomach and Duodenum with Hemorrhage
53784	**Dieulofoy Lesion (Hemorrhagic) of Stomach and Duodenum**
54000-54090	Acute Appendicitis
54100-54190	Appendicitis, unspecified
542	Other Appendicitis
55000-55013	Inguinal Hernia with Gangrene or Obstruction
55100-55190	Other Abdominal Hernia with Gangrene
55200-55290	Femoral, Ventral or Other Hernia with Obstruction
55300-55390	Other Hernia of Abdominal Cavity without mention of Obstruction or Gangrene
55700-55790	Acute, Chronic or Other Vascular Insufficiency of Intestine
55810-55830	Gastroenteritis or Colitis due to Radiation or Toxins
56000-56090	Intestinal Obstruction without Hernia
56202	Diverticulosis of Small Intestine with Hemorrhage
56203	Diverticulitis of Small Intestine with Hemorrhage
56212	Diverticulosis of Colon with Hemorrhage
56213	Diverticulitis of Colon with Hemorrhage
566	Abscess of Anal and Rectal Region
56700-56790	Peritonitis
56881	Hemoperitoneum (nontraumatic)
5693	Hemorrhage of Rectum and Anus
5695	Abscess of Intestines
56960-56969	Colostomy and Enterostomy Complications
56981-**56986**	Other Specified Disorders of Intestine
570	Acute and Subacute Necrosis of Liver
57110	Acute Alcoholic Hepatitis
57200-57220	Abscess of Liver; Hepatic Coma
5734	Hepatic Infarct
57400-57580	Acute Cholelithiasis
57610-57630	Other Disorders of Biliary Tract
5770	Acute Pancreatitis
57800-57890	Gastrointestinal Hemorrhage
58000-58090	Acute Glomerulonephritis
58300-58390	Nephritis or Nephropathy
58450-58490	Acute Renal Failure
59010-59030	Acute Pyelonephritis
59080-59081	Other Pyonephrosis
59200-59290	Calculus of Kidney or Ureter
59381	VascularDisorder of Kidney
59382	Ureteral Fistual

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59400-59490	Calculus of Lower Urinary Tract
5950	Acute Cystitis
59660-59670	Rupture or Hemorrhage of Bladder Wall
5970	Urethral Abscess
59910	Urethral Fistula
59950-59970	Prolapsed Urethral Mucosa; Urinary Obstruction, Unspecified; Hematuria
6010	Acute Prostatitis
60120-60190	Inflammatory Diseases of Prostate
6021	Congestion or Hemorrhage of Prostate
6031	Infected Hydrocele
6039	Hydrocele,unspecified
60400-60499	Orchiditis; Epididymitis
60710-60730	Balanoposthitis; Priapism; Other Inflammatory Disorders of Penis
60781-60783	Other Specified Disorders of Penis
6082	Torsion of Testes
60882	Hematospermia
60886	Edema of Penis
6140	Acute Salpingitis and Oophoritis
6143	Acute Parametritis and Pelvic Cellulitis
6145	Acute or Unspecified Pelvic Peritonitis (female)
6150	Acute Inflammatory Disease of Uterus, except cervix
6160	Cericitis and Endocervicitis
61630-61640	Abscess of Bartholon's Gland or Other Abcess of Vulva
62050-62070	Torsion of Ovary or Fallopian Tube; Hematoma or Laceration of Broad Ligament
6236	Vaginal Hematoma
6245	Hematoma of Vulva
6300	Hydatidiform Mole
63300-**63391**	Ectopic Pregnancy
63400-63492	Spontaneous Abortion
63500-63592	Legally Induced Abortion
63600-63692	Illegally Induced Abortion
63700-63782	Unspecified Abortion
63800-63882	Failed Attempted Abortion
63900-63990	Complications following Abortion or Ectopic or Molar Pregnancies
64000-64093	Hemorrhage in Early Pregnancy
64100-64193	Antepartum Hemorrhage; Placenta Previa; Abruptio Placentae
64200-64204	Hypertension Complicating Pregnancy; Childbirth; Puerperium
64210-64234	Hypertension Secondary to Renal Disease; Pre-existing or Transient
64240-64254	Mild, Severe, or Unspecified Pre-eclampsia

64260-64264	Eclampsia
64270-64274	Pre-eclampsia or Eclampsia Superimposed on Pre-Existing Hypertension
64290-64294	Unspecified Hypertension Complicating Pregnancy, Childbirth, or Puerperium
64310-64313	Hyperemesis Gravidarum with Metabolic Disturbance
64400-64413	Early or Threatened Labor
64420-64421	Early Onset of Delivery
64700-64784	Specific Infections Complicating Pregnancy
64800-64884	Specific Conditions Complicating Pregnancy
65000-65193	Normal Delivery; Twin, Triplet, Quadruplet, Other
65200-65393	Malposition and Malpresentation of Fetus
65400-65404	Congenital Abnormalities of Uterus
65410-65414	Tumors of Body of Uterus
65420-65423	Previous Cesarean Delivery
65430-65434	Retroverted and Incarcerated Gravid Uterus
65440-65444	Other Abnormalities of shape/position of Gravid Uterus or Neighboring Structures
65450-65494	Cervical Incompetence; Congenital or Acquired Abnormality of Cervix, Vagina,
65630-65633	Fetal Distress
65640-65643	Intrauterine Death
65810-65813	Premature Rupture of Membranes
65820-65823	Delayed Delivery after Spontaneous or Unspecified Rupture of Membranes
65830-65833	Delayed Delivery after Artificial Rupture of Membranes
65840-65843	Infection of Amniotic Cavity
65920-65923	Maternal Pyrexia during Labor, Unspecified
65930-65933	Generalized Infection during Labor
65970-65973	Abnormality in Fetal Heart Rate and Rhythm
66000-66093	Obstructed Labor
66100-66193	Abnormality of Forces of Labor
66200-66233	Prolonged Labor; First or Second Stage, unspecified
66300-66393	Umbilical Cord Complications
66400-66494	Trauma to Perineum and Vulva During Delivery
66500-66574	Other Obstetrical Trauma
66581-66584	Other Specified Obstetrical Trauma
66591-66594	Other Unspecified Obstetrical Trauma
66600-66714	Postpartum Hemorrhage and Other Postpartum Complications
66800-67004	Complications of Labor or Delivery
67100-67114	Venous Complications in Pregnancy and the Puerperium
67120-67154	Superficial; Deep Thrombophebitis, Other Phlebitis and Thrombosis
67180-67194	Other Venous Complications

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67220-67224	Pyrexia of Unknown Origin During the Puerperium
67300-67384	Obstetrical Pulmonary Embolism
67400-67494	Other Complications of Pregnancy
67501-67594	Infection of Breast and Nipple Associated with childbirth
67620-67624	Engorgement of Breast
71610-71619	Traumatic Arthropathy
71700-71770	Internal Derangement of Knee
71820-71829	Pathological Dislocation of Joint
71860-71865	Unspecified Intrapelvic Protusion of Acetabulum
71910-71919	Hemarthrosis
72000-72020	Ankylosing Spondylitis and Other Inflammatory Spondylopathies
72750-72769	Rupture of Synovium or Tendon
7280	Infective Myositis
72811-72813	Muscular Calcification and Ossification
72881	Interstitial Myositis
73000-73009	Acute Osteomyelitis
73310-73319	Pathologic Fracture
73393-73395	Stress Fracture
74510-74511	Transposition of Great Vessels; Double Outlet Right Ventricle
74520-74550	Tetralogy of Fallot; Common Ventricle; Ventricular Septal Defect; Ostium Secumdum Type Atrial Septal Defect
74600-74670	Anomalies of Pulmonary Valve
74681-74699	Other Specified and Unspecified Anomalies of Heart
7470	Patent Ductus Arteriosus
74710-74711	Coarctation of Aorta (preductal) (postductal) or Interruption of Aortic Arch
75161	Biliary Atresia
76000-76390	Fetal or Newborn Complications in Perinatal Period
76400-76499	Slow Fetal Growth and Fetal Malnutrition
76500-**76529**	Disorders Relating to Short Gestation and Unspecified Low Birthweight
76600-76629	Disorders relating to Long Gestation and High Birthweight
76700-76790	Birth Trauma
76800-76890	Intrauterine Hypoxia; Birth Asphyxia
76900-76990	Respiratory Distress Syndrome in Newborn
77000-77090	Other Respiratory Conditions of Fetus or Newborn
77100-**77189**	Infections Specific to the Perinatal Period
77200-77299	Fetal and Neonatal Hemorrhage
77300-77350	Hemolytic Disease of Fetus or Newborn
77400-77470	Other Perinatal or Neonatal Jaundice
77500-77590	Endocrine and Metabolic Disturbances Specific to the Fetus and Newborn
77600-77690	Hematological Disorders of Fetus and Newborn
77710-77790	Perinatal Disorders of Digestive System

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77800-77890	Conditions involving the Integument & Temperature Regulation of Fetus and Newborn
77900-77920	Convulsions, Cerebral Depression, Coma in Newborn
77940-77950	Drug Intoxication, Reaction, Withdrawal in Newborn
78000-78009	Coma And Stupor
7802	Syncope and Collapse
78031-78039	Convulsions
78100-78179	Symptoms Involving Nervous and Musculoskeletal Systems
7825	Cyanosis
7843	Aphasia
7848	Hemorrhage from Throat
78500-78510	Tachycardia, Unspecified; Palpitations
78540-78559	Gangrene; Shock without mention of Trauma
78603-78604	Apnea; Cheyne-Stokes Respiration
7861	Stridor
7863	Hemoptysis
78651	Percordial Pain
7880	Renal Colic
7887	Urethral Discharge
7907	Bacteremia
79200-79239	Nonspecified Abnormal Findings in other Body Substance or Body Structure
79800-79890	Sudden Death, cause unknown
7990	Asphyxia
7991	Respiratory Arrest
80000-83990	Fractures and Dislocations, various sites
84000-84519	Sprains and Strains, various sites
85000-89770	Skull Injuries; Internal Injuries; Open Wounds of various sites
90000-90490	Injuries to Blood Vessels
91800-91890	Superficial Injury of Eye and Adnexa
92000-92190	Contusions of Face or Head
92510-95990	Crushing Injuries; Foreign Bodies; Burns; Spinal Injuries
96000-99510	Poisoning; Toxic Effects of Substances
99530-99570	Other Effects of External Causes
99580-99890	Mechanical Complications and Other Complications of External Causes
V460	Aspirator (dependence on machine)
V461	Respirator (dependence on machines)
V462	**Other Dependence on Machine**
V468	Other Enabling Machine
V6121	Child Abuse
V6122	Counseling for Perpetrator of Parental Child Abuse

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V714	Observation following other accident (MVA)
V715	Observation following alleged rape or seduction
V716	Observation following other inflicted injury
V7181	Observation for Abuse and Neglect
V7182	**Observation and Evaluation for Suspect Anthrax Exposure**
V7183	**Observation and Evaluation for Suspect Other Biological Exposure**
E8000-E9590	All will pay within this range
E9601-E9689	All will pay within this range
E9700-E9980	All will pay within this range

0408	Other Specified Bacterial Disease
04100-04109	Streptoccus Unspecified; Groups A, B, C, D, G and Other
04110-04200	Staphylococcus; Penmococcus; Other Specified Bacterial Infections
0460-0469	Slow Virus Infection of Central Nervous System
0510-0519	Cowpox; Pseudocowpox; Paravaccinia; Unspecified
0540	Eczema Herpeticum
0552	Postmeasle Otitis Media
05579-05590	Other Measles with and without complications
05700-05790	Other Viral Exanthemata
0669	Arthropod-borne Viral Diseases; Unspecified
0709	Unspecified Viral Hepatitis without hepatic coma
0743-0769	Hand; Foot; Mouth Disease; Other Specified Disease due to Coxsackie Virus; Trachoma
0770-0773	Other Disease of Conjunctiva due to Viruses and Chlamydia
0778-0785	Other Viral Conjunctivitis; Other Specified; and Unspecified Diseases due to Viruses and Chlamydiae
07881-07889	Other Specified Diseases due to Coxsackie Virus
07900-07959	Viral and Chlamydial Infections in conditions classified elsewhere and of Unspecified Site; Retrovirus
07981-07989	Other Specified Viral and Chlamydial Infections
07998-07999	Unspecified Viral and Chlamydial Infections in Conditions classified elsewhere and Site Unspecified
0982	Gonococcal Infection; Chronic, of Lower Genitourinary Tract
09830-09839	Gonococcal; Chronic, of Upper Genitourinary Tract
10089	Leptospiral; Other
10090	Leptospirosis, Unspecified
101	Vincent's Angina
10200-10290	Yaws
10300-10390	Pinta
10400-10490	Other Spirochetal Infections
11000-11090	Dermatophytosis
11100-11190	Dermatophytosis; Other and Unspecified
11200-11230	Candidiasis
1125	Disseminated Candidiasis
11289-11290	Other Candidiasis and of Unspecified Sites
11400-11410	Primary; Extrapulmonary; Other Coccidioidomycosis
11430-11490	Other Forms of Coccidioidomycosis; Unspecified Primary or Pulmonary Coccidioidomycosis
11500	Histoplasmosis without mention of manifestation
11509	Other Histoplasmosis without mention of manifestation

11510	Infection by Histoplasma Duboisii without mention of manifestation
11519	Other Infection by Histoplasma Duboisii
11590	Histoplasmosis; Unspecified without mention of manifestation
11599	Other Histoplasmosis
11600-11620	Blastomycotic; Paracoccidiodomucosis; Lobomycosis
11700-11800	Other Mycoses; Infection by Dematiacious Fungi (Phaehyphomycosis); Opportunistic; Unspecified and Other Mycoses
12000-12090	Schistos iasis (bilharziasis)
12100-12190	Other Trematode Infection
12200-12290	Echinococcosis
12300-12390	Other Cestode Infection
124	Trichinosis
12500-12590	Filarial Infection and Dracontiasis
12600-12690	Ancylostomiasis and Necatoriasis
12700-12790	Other Intestinal Helminthiases
12800-12890	Other and Unspecified Helminthiases
129	Intestinal Parasitism, Unspecified
13100-13390	Trichomoniasis; Pediculosis and Phthirus Infection; Acariasis
13400-13620	Other Infestations; Other and Unspecified Infectious and Parasitic Diseases
13640-13690	Other and Unspecified Infectious and Parasitic Diseases
13700-13800	Late Effects of Tuberculosis
13900-13980	Late Effects of Other Infectious and Parasitic Disease
14000-14490	Malignant Neoplasm of Lip; Tongue; Major Salivary Gland; Gum; Floor of Mouth
14500-14990	Malignant Neoplasm of Other and Unspecified Parts of Mouth; Oropharynx; Nasopharynx; Hypopharynx; and Other Ill-Defined Sites of Lip, Oral Cavity and Pharynx
15000-15480	Malignant Neoplasm of Esophagus; Stomach; Small Intestine including Duodenum, Colon, Rectum, Rectosigmoid Junction, and Anus
15500-15990	Malignant Neoplasm of Liver, Intrahepatic Bile Ducts, Gallbladder, Extrahepatic Bile Ducts, Pancreas, Retroperitoneum and Other Ill Defined Sites of the Digestive Organs and Peritoneum
16000-16590	Malignant Neoplasm of Nasal Cavities, Larynx, Trachea, Bronchus, Lung, Pleura, Thymus, Heart, Mediastinum, Upper Respiratory Tract, part unspecified

17000-17390	Malignant Neoplasm of Bone; Articular Cartilage; Connective and Soft Tissue, Skin and Other Malignant Neoplasm of Skin
17400-17900	Malignant Neoplasm of Female and Male Breast; Kaposi's Sarcoma; Uterus, parts unspecified
18000-18790	Malignant Neoplasm of Cervix Uteri, Uterus, Ovary and Other Uterine Adnexa; Other and Unspecifed Female Genital Organs, Testis, Penis and Other Male Genital Organs
18800-18990	Malignant Neoplasm of Bladder, Kidney and Other Unspecified Urinary Organs
19000-19390	Malignant Neoplasm of Eyeball, Brain, Other and Unspecified Parts of Nervous System
19400-19690	Malignant Neoplasm of Other Endocrine Glands and Related Structure, Ill-Defined Sites
19700-19780	Secondary and Unspecified Malignant Neoplasm of Lymph Nodes, Respiratory and Digestive System
19800-19910	Secondary Malignant Neoplasm of Other Specified Sites; without Specified Sites
20000-20088	Lymphosarcoma; Reticilosarcoma; Burkitt's Tumor; Other Named Variants
20100-20148	Hodgkin's Disease, Hodgkin's Granuloma, Hodgkin's Sarcoma, Lymphocytic-Histiocytic Predominance
20150-20198	Nodular Sarcoma, Mixed Cellularity, Lymphocytic Depletion, Hodgkin's Disease- Unspecified
20200-20238	Nodular Lymphoma; Mycosis Fungoides; Sezary's Disease; Malignant Histiocytosis
20240-20268	Leukemic Reticuloendotheliosis; Letter-Siwe Disease; Malignant Mast Cell Tumors
20280-20288	Other Lymphomas
20290-20298	Other and Unspecified Malignant Neoplasms of Lympoid, Histiocytic Tissue
20300-20311	Multiple Myeloma, Plasma Cell Leukemia
20380-20381	Other Immunoproliferative Neoplasms
20400-20411	Acute or Chronic Lymphoid Leukemia
20420-20421	Subacute Leukemia
20480-20491	Other and Unspecified Lymphoid Leukemia
20500-20531	Myeloid Leukemia, Chronic or Subacute; Myeloid Sarcoma
20580-20591	Other and Unspecified Myeloid Leukemia
20600-20621	Acute Monocytic Leukemia, Chronic, Subacute
20680-20691	Other and Unspecified Monocuutic Leukemia
20700-20721	Other Specified Leukemia; Chronic Erythemia

20780-20891	Megakaryicytic Leukemia; Leukemia of Unknown Cell Type; Other and Unspecified Leukemia of Unknown Cell Types
21000-21390	Benign Neoplasm of Lip, Oral Cavity, Pharynx; Other Parts of Digestive System, Respiratory, Intrathoracic Organs, Bone and Cartilage
21400-22290	Lipoma, Benign Neoplasm of Connective, Other Soft Tissue, Skin, Uterine Leiomyoma, Uterus, Other Female Genital Organs, Other Male Genital Organs
22300-22799	Benign Neoplasm of Kidney, Other Urinary Organs, Other Specified Sites of Urinary Organs, Eye, Brain, Other Parts of Nervous System, Other Endocrine Glands and Related Structures
22800-22990	Hemangioma, Lymphangioma, Any Site, Benign Neoplasm of Other and Unspecified Sites
23000-23490	Carcinoma in Situ of Digestive Organs, Respiratory System, Skin, Breast, Genitourinary System, Other and Unspecified Sites
23500-23760	Neoplasms of Uncertain Behavior of Digestive System, Respiratory System, Genitourinary Organs, Unspecified Urinary Organs, Endocrine Glands and Nervous System
23770-23790	Neurofibromatosis
23800-23990	Neoplasms of Uncertain Behavior of Other and Unspecified Sites and Tissues, Other Unspecified Nature
24000-24090	Goiter, Specified as Simple or Unspecified
24100-24190	Nontoxic Nodular Goiter
24300-24490	Congential or Aquired Hypothroidism
24510-24590	Subacute, Chronic, Other and Unspecified Thyroiditis
24600-24620	Other Disorders of Thyroid
24680-24690	Other Specified and Unspecified Disorders of Thyroid
25000-25001	Diabetes Mellitus without mention of Complications, Type I and II, controlled
25040-25041	Diabetes Mellitus with Renal Manifestations, Type I and II, controlled
25050-25051	Diabetes Mellitus with Ophthalamic Manifestations, Type I and II, controlled
25060-25061	Diabetes Mellitus with Neurological Manifestations, Type I and II, controlled
25070-25071	Diabetes Mellitus with Peripheral Circulatory Disturbances, Type I and II, controlled
25080-25081	Diabetes Mellitus with Other Specified Manifestations, Type I and II, controlled

25090-25091	Diabetes Mellitus with Other Unspecified Complications, Type I and II, controlled
25130-25190	Postsurgical Hypoinsulinemia, Abnormality of Secretions of Glucagon or Gastrin, Other Specified and Unspecified Pancreatic Internal Secretion
2520	Hyperparathyroidism
25280-25290	Other Specified and Unspecified Disorders of Parathyroid Gland
25300-25340	Acromegaly, Giantism, Panhypopituitarism, Pituitary Dwarfism, Other Unspecified and Specified Anterior Pituitary Hyperfunction
25360-25390	Other Disorders of Neurohypophysis, Iatrogenic Pituitary Disorders, Other Syndrome of Diecephalohhypophyseal Origin, Unspecified Disorders of Pituitary
2540-25490	Diseases of Thymus Gland
25500-25530	Cushing's Syndrome, Hyperaldosteronism, Adrenogenital Disorders, Other Corticoadrenal Overactivity
25550-25590	Other Adrenal Dysfunction, Other Specified and Unspecified Disorders of Adrenal Gland
25600-25690	Ovarian Dysfunction
25700-25790	Testricular Hyperfunction
25800-25890	Polygandular Dysfunction and Related Disorders
25900-26100	Other Endocrine Disorders
26300-26390	Other and Unspecified Protein-Calorie Malnutrition
26400-26990	Vitamin A, Thiamine, Niacin, B-Complex Components, Vitamin D, Other Nutritional Deficiencies
27000-27190	Disturbance of Amino-Acid Transport, Disorder of Carbohydrate Transport and Metabolism
27200-27390	Disorders of Lipoid, Plasma Protein Metabolism
27410-27490	Other and Unspecified Gouty Neuropathy, Uric Acid Nephrolithiasis, Gouty Tophi of ear and other sites, Specified or Unspecified Manifestations
27500-27540	Disorders of Mineral or Calcium Metabolism
27549-27590	Other and Specified Disorders of Mineral Metabolism
2769	Electrolytes and Fluid Disorders not elsewhere classified
27700-27790	Cystic Fibrosis; Other and Unspecified Disorders of Metabolism
27800-27880	Obesity and Other Hyperalimentation
27900-27990	Deficiency of Humoral Immunity, Disorders of Deficiency of Cell-Mediated Immunity
28000-28250	Iron Deficiency Anemias, Other Deficiency Anemias, Hereditary Hemolytic Anemias

28260-28261	Sickle Anemia, Unspecified; Hb-S Disease without mention of crisis
28263-28310	Sickle Cell/Hb-C Disease; Other Specified Heredity Hemolytic Anemias, Autoimmune and Non-autoimmune Hemolytic Anemias
28319-28500	Other Non-Autoimmune Hemolytic Anemais; Hemoglobinuria due to Hemolysis from External Cause; Acquired Hemolytic Anemias; Aplastice Anemias; Seroblastic Anemia
28521-28590	Other Specified and Unspecified Anemias
28800-28890	Diseases of White Blood Count
28900-28940	Polycythemia, Secondary; Chronic Lymphadenitis; Nonspecific Mesenteric Lymphadenitis; Hypersplenism
28950-28970	Diseases of Spleen, Unspecified; Chronic Congestive Splenomegaly; Familial Polycthemia; Other Diseases of Spleen
28980-28990	Other Specified and Unspecified Diseases of the Blood and Blood Forming Organs
2900	Senile Dementia
29010	Presentile Dementia
29012-29013	Presentile Dementia with Delusional or Depressive Features
29020-29021	Senile Dementia with Delusional or Depressive Features
29040	Atheriosclerotic Dementia, Uncomplicated
29042-29090	Atheriosclerotic Dementia with Delusional or Depressive Features; Uncomplicated; Unspecified Senile Psychotic Condition
2911	Alcohol Amnestic Syndrome
2912	Other Alcoholic Dementia
2914	Idiosyncratic Alcohol Intoxication
2915	Alcoholic Jealousy
29189-29190	Other Specified Alcoholic Psychosis
2920	Drug Withdrawal Syndrome
29211	Drug Induced-Organic Delusional Syndrome
2922	Pathological Drug Intoxication
29282-29290	Drug Induced Dementia; Drug Induced Amnestic Syndrome; Other Specified Drug Induced Mental Disorders; Other Organic Psychotic Conditions (chronic)
2931	Transient Organic Psychotic Conditions-Subacute
29381-29390	Other Specified Transient Organic Mental Disorders; Unspecified Transient Organic Mental Disorders
2940	Amnestic Syndrome
29410-29490	Other Organic Psychotic Conditions (chronic)
29500-29502	Schizophrenic Disorder-Simple Type Chronic

29505	Schizophrenic Disorder-Simple Type in Remission
29510-29512	Schizophrenic Disorder-Disorganized Type; Unspecified; Subchronic; Chronic
29515	Schizophrenic Disorder-Disorganized Type in remission
29520-29522	Schizophrenic Disorder-Catatonic Type; Unspecified; Subchronic; Chronic
29525	Schizophrenic Disorder-Catatonic Type in remission
29530-29532	Schizophrenic Disorder-Paranoid Type; Unspecified; Subchronic; Chronic
29535	Schizophrenic Disorder-Paranoid Type in remission
29540-29542	Acute Schizophrenic Episode; Unspecified; Subchronic; Chronic
29545	Acute Schizophrenic Episode in remission
29550-29552	Latent Schizophrenic-Unspecified; Subchronic; Chronic
29555	Latent Schizophrenic in remission
29560-29562	Residual Schizophrenic; Unspecified; Subchronic; Chronic
29565	Residual Schizophrenic in remission
29570-29572	Schizophrenic Disorder-Schizo-Affective Type; Unspecified; Subchronic; Chronic
29575	Schizophrenic Disorder-Schizo-Affective Type in remission
29580-29582	Other Specified Types of Schizophrenic; Unspecified; Subchronic; Chronic
29585	Other Specified Types of Schizophrenic in remission
29590-29592	Unspecified Schizophrenic; Unspecified; Subchronic; Chronic
29595	Unspecified Schizophrenic in remission
29600-29602	Affective Psychoses-Manic Disorder-Single Episode; Unspecified; Mild; Moderate
29605-29606	Affective Psychoses-Manic Disorder-Single Episode; Unspecified; Mild, Moderate; in Partial; Unspecified Remission
29610-29612	Affective Psychoses-Manic Disorder-Recurrent Episode; Unspecified; Mild; Moderate
29615-29616	Affective Psychoses-Manic Disorder-Recurrent Episode; Unspecified; Mild; Moderate; in Partial; Unspecified Remission
29620-29622	Affective Psychoses-Major Depression Disorder-Single Episode; Unspecified; Mild; Moderate
29625-29626	Affective Psychoses-Major Depression Disorder-Single Episode; Unspecified; Mild; Moderate; in Partial; Unspecified Remission
29630-29632	Affective Psychoses-Major Depression Disorder-Recurrent Episode; Unspecified; Mild; Moderate
29635-29636	Affective Psychoses-Major Depression Disorder-Recurrent Episode; Unspecified; Mild; Moderate; in Partial; Unspecified Remission
29640-29642	Affective Psychoses-Bipolar Affective Disorder-Manic; Unspecified; Mild; Moderate
29645-29646	Affective Psychoses-Bipolar Affective Disorder-Manic;

	Unspecified; Mild; Moderate; in Partial; Unspecified Remission
29650-29652	Affective Psychoses-Bipolar Affective Disorder-Depressed; Unspecified; Mild; Moderate
29655-29656	Affective Psychoses-Bipolar Affective Disorder-Depressed; Unspecified; Mild; Moderate; in Partial; Unspecified Remission
29660-29662	Affective Psychoses-Bipolar Affective Disorder-Mixed; Unspecified; Mild; Moderate
29665-29670	Affective Psychoses-Bipolar Affective Disorder-Mixed; Unspecified; Mild; Moderate; in Partial; Unspecified Remission
29680-29699	Manic Depressive Psychosis
29700-29790	Paranoia; Paraphrenia; Shared Paranoid Disorder; Other Specified or Unspecified Paranoid Disorder
29800-29890	Other Non-organic Psychosis
29900-29991	Psychoses with Origin Specific to Childhood
30000-30009	Anxiety States
30010-30019	Hysteria, Unspecified; Other and Unspecified Fictitious Illness
30020-30090	Phobia Disorders; Other Neurotic Disorders
30100-30170	Personality, Affective Personality, Schizoid Personality, Histrionic Personality Disorders
30181-30290	Other Personality Disorders; Sexual Deviations and Disorders; Trans-sexualism; Psychosexual Dsyfunction; Other Specified Psychosexual Disorders
30300-30393	Alcohol Dependence Syndrome; Other or Unspecified Alcohol Dependence
30400-30453	Opioid Type; Barbiturate and Similarly Acting Sedative or Hypnotic; Cocaine; Cannabis; Amphetamine and Other Psychostimulant; Hallucinogen Dependence
30460-30493	Other Specified Drug; Combinations of Opioid Type with Any Other; Combinations of Drug Dependence excluding Opioid Type Dependence
30500-30543	Alcohol Abuse; Tobacco Use Disorder; Cannibis Abuse; Hallucinogen Abuse; Barbiturate and Similarly Acting Sedative or Hypnotic Abuse
30550-30593	Opioid Abuse; Cocaine Abuse; Amphetamine or Related Acting Sympathomimetic Abuse; Antidepressant Type Abuse; Other, Mixed, or Unspecified Drug Abuse
30600-30690	Physiological Malfunction /arising from Mental Factors; Psychogenic Genitourinary Malfunction
30700-30790	Special Symptoms or Syndromes, not elsewhere classified; Tics; Sterotyped Repetitive Movements; Specific Disorders of Sleep of Nonorganic Origin; Psychalgia
30800-30990	Acute Reaction to Stress; Adjustment Reaction and with Predominant Disturbance of Other Emotions; Other Specified Adjustment Reaction
31000-31110	Frontal Lobe Syndrome; Organic Personality Syndrome; Other

	Specified and Unspecified Non-psychotic Mental Disorders due to Organic Brain Damage; Disturbance of Conduct
31200-31239	Undersocialized Conduct Disorder, Aggressive and Unaggressive Type; Socialized Conduct Disorder; Disorders of Impulse Control, not elsewhere classified
3124	Mixed Disturbance of Conduct and Emotions
31281-31310	Other Specified Disturbances of Conduct, not elsewhere classified; Disturbances of Emotions Specific to Childhood or Adolescence-Overanxious Disorder
31321-31490	Sensitivity, Shyness and Social Withdrawal Disorder; Other or Mixed Emotional Disturbances of Childhood or Adolescence; Attention Deficit Disorder
31500-31790	Specific Reading Disorder; Developmental Speech or Language Disorder
31800-31990	Other Specified Mental Retardation
33000-33170	Cerbral Degenerations Usually Manifest in Childhood; Other Cerebral Degeneration
33181-33190	Reye's Syndrome; Other and Unspecified Cerebral Degeneration
33200-33370	Parkinson's Disease; Other Extrapyramidal Disease and Abnormal Movement Disorder
33381-33382	Blepharospasm; Orofacial Dyskinesia
33384-33389	Organic Writer's Cramp; Other Fragments of Torsion Dystonia
33390-33391	Unspecified Extrapyramidal Disease and Abnormal Movement Disorder; Stiff-man Syndrome
33393-33399	Benign Shuddering Attacks; Other and Unspecified Extrapyramidal Diseases and Abnormal Movement Disorder
33400-33420	Friedreich's Ataxia; Hereditary Spastic Paraplegia; Primary Cerebellar Degeneration; Primary Cerebellar Degeneration
33440-33590	Cerbebellar Ataxia in Diseases classified elsewhere; Other and Unspecified Spinocerebellar Diseases; Anterior Horn Cell Diseases; Spinal Muscular Atrophy; Motor Neuron Disease

3360	Syringomyelia and Syringobulbia
33620-33690	Subacute Combined Degeneration of Spinal Cord in Diseases classified elsewhere; Myelopathy in other Diseases Classified Elsewhere; Other Myelopathy; Unspecified Diseases of Spinal Cord
33700-34190	Disorders of Autonomic Nervous System; Reflex Sympathetic Dystrophy; Other Demyelinating Diseases of Central Nervous System
34200-34390	Hemiplegia; Hemiparesis; Other Paralytic Syndromes
34400-34490	Quadriplegia; Quadriparesis; Monoplegia of Upper and Lower Limb; Cauda Equina Syndrome; Other Specified Paralytic Syndromes
34500-34510	Generalized Convulsive or Non-Convulsive Epilepsy
345450-34551	Partial Epilepsy with Impairment of Consciousness
34560	Infantile Spasms, with Intractable Epilepsy
34570	Epilepsia Partialis Continus
34580	Other Forms of Epilepsy, with Intractable Epilepsy
34590	Epilepsy, Unspecified
34600	Classic Migraine
34610	Common Migraine
34620	Variants Migraine
34680	Other Forms Migraine
34690	Unspecified Migraine
347	Cataplexy and Narcolepsy
3480	Cerebral Cysts
3482	Benign Intracranial Hypertension
34880-34890	Other and Unspecified Conditions of Brain
3492	Disorders of Meninges, not elsewhere classified
34989-34990	Other and Unspecified Disorders of Nervous System
3502	Atypical Face Pain
3508	Other Trigeminal Nerve Disorders
3509	Unspecified Trigeminal Nerve Disorders
3511	Geniculate Ganglionitis
3518	Other Facial Nerve Disorders
3519	Unspecified Facial Nerve Disorders
35200-35390	Disorders of Other Cranial Nerves; Nerve Root and Plexus Disorders
35400-35590	Mononeuritis of Upper Limb and Mononeuritis Multiplex; Mononeuritis of Lower Limb-Lesion of Sciatic Nerve; Other Mononeuritis of Lower Limb
35600-35690	Hereditary and Idopathic Neuropathy
35710-35790	Inflammatory and Toxic Neuropathy
35810-35890	Myasthenic Syndrome in Disease Classified Elsewhere, Toxic Myoneural Disorders; Other Specified and Unspecified

	Myoneural Disorders
35900-35990	Congenital and Progressive Hereditary Muscular Dystrophy Myotonic Disorders; Myopathy in Endocrine Diseases classified elsewhere; Symptomatic Inflammatory Myopathy in Diseases Classified Elsewhere; Other and Unspecified Myopathies
36020-36044	Degenerative Disorder of Globe; Hypotony of Eye; Degenerated Globe or Eye
36050-36090	Retained (old), Intraocular Foreign Body, Magnetic and Nonmagnetic; Other Disorders of Globe
36106-36107	Old Retained Detachment, Partial, Total, Subtotal
36110-36119	Retinoschisis and Retinal Cysts
36130-36133	Retinal Defect without detachment
36201-36229	Diabetic Retinopathy; Other Background Retinopathy and Retinal Vascular Changes; Other Proliferative Retinopathy
36250-36277	Degeneration of Macula and Posterior Pole; Peripheral Retinal Degeneration
36282-36290	Hereditary Retinal Dsytrophies; Other Retinal Disorders; Unspecified Retinal Disorders
36300-36322	Focal Chorioretinitis and Focal Retinochorioretinitis; Disseminated Chorioretinitis and Disseminated Retinchoroiditis; Other and Unspecified Forms of Chorioretinitis and Retinochoroiditis
36330-36357	Chorioretinal Scars; Choroid Degeneration; Hereditary Choroid Dystrophies
36380-36390	Other and Unspecified Disorder of Choroid
36410-36411	Chronic Iridocyclitis, Unspecified or in Diseases classified elsewhere
36442	Rubeosis Iridis
36451-36490	Degeneration of Iris and Ciliary Body; Cysts of Iris, Ciliary Body, Anterior Chamber; Adhesions and Disruptions of Iris and Ciliary Body
36500-36503	Borderline Glaucoma (glaucoma suspect)
36510-36521	Open-angle Glaucoma; Primary Angle-closure Glaucoma
36523-36524	Chronic Angle-closure Glaucoma; Residual Stage of Angle-closure Glaucoma

36531-36564	Corticosteroid-induced Glaucoma; Glaucoma Associated with Congenital Anomalies, Dystrophies, and Systemic Syndromes; Glaucoma Associated with Disorders of Lens; Glaucoma Associated with Other Ocular Disorders
36581-36690	Other Specified Forms of Glaucoms; Infantile, Juvenile, Presenile, Senile, Traumatic Cataracts; Cataract Secondary to Ocular Disorders; Cataract Associated with Other Disorders; After-Cataract
36700-36790	Disorders of Refraction and Accommodation; Astigmatism; Anisometropia and Aniselkonia; Disorders of Accommodation; Other Disorders of Refraction and Accommodation
36800-36810	Amblyopia Ex Anopsia; Subjective Visual Disturbances, Unspecified
36813-36820	Visual Discomfort; Visual Distortions and Entoptic Phenomena; Psychophysical Visual Disturbances; Diplopia
36830-36890	Other Disorders or Binocular Vision; Visual Field Defects; Color Vision Deficiencies; Night Blindness
36900-36990	Profound Impairment, Both Eyes; Moderate or Severe Impairment, Better eye, Profound Impairment Lesser Eye; Moderate or Severe Impairment, Both Eyes; Profound Impairment, One Eye; Moderate or Severe Impairment, One Eye
37001-37002	Marginal Corneal Ulcer; Ring Corneal Ulcer
37004-37005	Mycotic or Perforated Corneal Ulcer
37007	Mooren's Ulcer
37031-37035	Certain Types of Keratoconjunctivitis
37049	Other Keratoconjunctivitis
37060-37116	Corneal Neovascularization; Corneal Scars and Opacities; Corneal Pigmentation and Deposits
37130-37190	Changes of Corneal Membranes; Corneal Degenerations; Hereditary Corneal Dystrophies; Keratoconus; Other Corneal Deformities; Other Corneal Disorders
37203-37204	Other Mucopurulent; Pseudomembranous Conjunctivitis
37210-37215	Chronic Conjunctivitis
37230-37231	Conjunctivitis, Unspecified; Rosacea Conjunctivitis
37239	Other Conjunctivitis
37240-37264	Pterygium; Conjunctival Degenerations and Deposits; Conjunctival Scars
37274-37290	VascularAbnormalities of Conjunctiva; Conjunctiva Cysts; Other and Unspecified Disorders of Conjunctiva
37300	Blepharitis, Unspecified

3732	Chalazion
37331-37390	Eczematous Dermatitis of Eyelid; Noninfectious Dermatoses of Eyelid
37400-37446	Entropian and Trichiasis of Eyelid; Ectropion; Lagophthalmos; Ptosis of Eyelid; Other Disorders Affecting Eyelid Function
37450-37456	Degenerative Disorders of Eyelid and Periocular Area
37482-37485	Hemorrhage, Edema, Elephantiasis, Cysts, Vascular Anomalies
37487-37490	Dermatochalasis of Eyelid; Other and Unspecified Disorders of Eyelid
37502-37503	Chronic Dacryoadenitis; Chronic Enlargement of Lacrimal Gland
37511-37522	Other Disorders of Lacrimal Gland; Epiphora
37541-37590	Chronic Inflammation of Lacrimal Passages; Stenosis and Insufficiency of Lacrimal Passages; Other Changes of Lacrimal Passages; Other Disorders of Lacrimal System
37610-37613	Chronic Inflammatory Disorders of Orbit
37621-37622	Endocrine Exophthalmos
37630-37631	Exophthalmos, Unspecified; Constant Exophthalmos
37640-37647	Deformity of Orbit
37650-37652	Enophthalmos, Unspecified as to cause; Enophthalmos due to Atrophy of Orbital Tissue, Trauma or Surgery
3766	Retained (old) Foreign Body
37681-37690	Other Orbital Disorders
37700	Papilledema, Unspecified
37702-37724	Papilledema Associated with Increase Intracranial Pressure, Decreased Ocular Pressure, with Retinal Disorder; Foster-Kennedy Syndrome; Optic Atrophy; Other Disorders of Optic Disc
37730-37731	Optic Neuritis, Unspecified; Optic Papillitis
37733-37739	Nutritional Optic Neuropathy; Toxic Optic Neuropathy; Other
37751-37845	Disorders of Optic Chiasm; Disorders of Other Visual Pathways; Disorders of Visual Cortex; Esotropia; Exotropia; Intermittent Heterotropia; Other and Unspecified Heterotropia; Heterophoria
37850	Paralytic Strabismus
37855-37856	External or Total Ophthalmoplegia
37860-37919	Mechanical Strabismus; Other Specified Strabismus; Other disorders of Binocular Eye Movements; Scieritis and Episcleritis; Other Diseases of Sclera
37921-37922	Vitreous Degeneration; Crystalline Deposits in Viterous
37924-37925	Other Vitreous Opacities
37929	Other Disorders of Vitreous
37931	Aphakia
37939	Other Disorders of Lens
37940-37999	Dissocated Nystagmus; Other Forms of Nystagmus; Deficiencies of Saccadic Eye or Smooth Pursuit Movement; Other

	Irregularities of Eye Movement; Other Specified Disorders of Eye and Adnexa
38000	Perichondritis of Pinna, unspecified
38002	Perichondritis of Pinna, chronic
38015-38016	Chronic Muycotic Otitis Externa; Other Chronic Infective Otitis Externa
38021	Cholesteatoma of External Ear
38023	Other Chronic Otitis Externa
38030	Disorder of Pinna, unspecified
38032	Acquired Deformities of Auricle or Pinna
38039	Other Acquired Deformities of Auricle or Pinna
3804	Impacted Cerumen
38050-38053	Acquired Stenosis of External Ear Canal
38081-38090	Other Disorders of External Ear
38100-38190	Acute or Chronic Serous Otitis Media; Chronic Mucoid Otitis Media; Eustachian Salpingitis; Obstruction of Eustachian Tube; Other Disorders of Eustachian Tube
38210-38290	Chronic Tubotympanic or Atticoantral Suppurative Otitis Media; Unspecified or Unspecified Chronic Suppurative Otitis Media; Unspecified Otitis Media
3831	Chronic Mastoiditis
38320-38390	Petrositis; Complications Following Mastoidectomy; Other Disorders of Mastoid
38409-38410	Chronic or Other Myringitis without mention of Otitis Media
38481-38519	Other Specified Disorders of Tympanic Membrane; Other Disorders of Middle Ear and Mastoid; Tympanosclerosis; Adhesive Middle Ear Disease
38521-38524	Impaired Mobility of Malleus or Other Ear Ossicles; Partial Loss or Necrosis of Ear Ossicles
38530-38535	Cholesteatoma of Middle Ear and Mastoid
38582	Cholesterin Granuloma
38589-38590	Other and Unspecified Disorder of Middle Ear and Mastoid
38604	Inactive Meniere's Disease
38640-38802	Labyrinthine Fistula; Labyrinthine Dysfunction; Otosclerosis; Degenerative and Vascular Disorders of Ear
38810	Noise effects on Inner Ear, unspecified
38830-38850	Tinnitus; Other Abnormal Auditory Perception
38860	Otorrhea, Unspecified
38869	Presbyacusis
38872	Otalgia, Referred Pain
3888	Other Disorders of Ear
3889	Unspecified Disorders of Ear
38900-38908	Conductive Hearing Loss, Unspecified or External Ear
38910-38990	Sensorineural Hearing Loss, Unspecified; Sensory Hearing Loss
39000-39001	Rheumatic Fever without mention of heart involvement

39200-39890	Rheumatic Chorea; Diseases of Mitral Valve; Diseases of Aortic Valve; Diseases of Mitral and Aortic Valves; Diseases of Other Endocardial Structures
39899	Other Rheumatic Heart Disease
40110- 40190	Essential Hypertension
40210	Benign Hypertensive Heart Disease without congestive heart failure
40290	Unspecified Hypertensive Heart Disease without congestive heart failure
40300	Malignant Hypertensive Renal Disease without mention of renal disease
40310	Benign Hypertensive Renal Disease without mention of renal disease
40390	Unspecified Hypertensive Renal Disease without mention of renal failure
40410	Benign Hypertensive Heart and Renal Disease without mention of CHF or renal failure
40490	Unspecified Hypertensive Heart and Renal Disease without mention of CHF or renal failure
40509	Malignant and Other Secondary Hypertension
40511-40519	Benign Secondary Hypertension
40591-40599	Unspecified Secondary Hypertension
41200-41201	Old Myocardial Infarction
41400-**41406**	Coronary Atherosclerosis
41419-41490	Other Specified or Unspecified Forms of Chronic Ischemic Heart Disease
41600-41790	Chronic Pulmonary Heart Disease; Other Diseases of Pulmonary Circulation
42400-42430	Other Diseases of Endocardium
42500-42590	Cardiomyopathy
42820	**Systolic Heart Failure, Unspecified**
42822	**Systolic Heart Failure, Chronic**
42830	**Diastolic Heart Failure, Chronic**
42832	**Diastolic Heart Failure, Unspecified**
42840	**Combined Diastolic and Systolic Heart Failure, Unspecified**
42842	**Combined Diastolic and Systolic Heart Failure,Chronic**
42910-42930	Myocardial Degeneration; Unspecified Cardiovascular Diseases; Cardiomegaly
42981-42990	Other Ill Defined Heart Diseases
43700-43710	Cerebral Atherosclerosis; Other Generalized Ischemic Cerebrovascular Disease
4374	Cerebral Arteritis
4375	Moyamoya Disease
43780-43790	Other and Unspecified Ill-Defined Cerebrovascular Disease
43800-43890	Late Effects of Cerebrovascular Disease; Speech and Language

	Deficits; Hemiplegia, Hemiparesis; Monoplegia of Upper or Lower Limb; Other Paralytic Syndrome; Other Late Effects of Cerebrovascular Disease
44000-44029	Atherosclerosis of Aorta; Renal Artery; Native Arteries of Extremities; Unspecified Atherisclerosis of Extremities
44030-44090	Artherosclerosis of Bypass Graft of Extremities
44300-44319	**Other Peripheral Vascular Disease**
44380-44390	**Other Specified Peripheral Vascular Disease**
44800-44890	Diseases of Capillaries
45400-45490	Varicose Veins of Lower Extremities
45500-45590	Hemorroids
4561	Esophageal Varcies without mention of bleeding
45621-45680	Esophageal Varices in Diseases classified elsewhere
45780-45790	Other and Unspecified Noninfectious Disorders of Lymphatic Channels
4581	Chronic Hypertension
4589	Hypotension, Unspecified
45910-45920	Other Diseases of Circulatory System
45930-45939	**Chronic Venous Hypertension**
45981-46000	Other Specified Disorders of Circulatory System; Acute Nasopharyngitis (common cold)
46100-46410	Acute Sinusitis; Acute Laryngitis and Tracheitis
46420	Acute Laryngotracheitis
46450	Supraglottitis without Obstruction
46500-46590	Acute Upper Respiratory Infections of multiple or unspecified sites
4660	Acute Bronchitis
470	Deviated Nasal Septum
47100-47490	Nasal Polyps; Chronic Pharyngitis and Nasophayngitis; Chronic Sinusitis; Chronic Tonsillitis and Adenoiditis
47600-47810	Chronic Laryngitis and Laryngotracheitis; Allergic Rhinitis; Other Diseases of Upper Respiratory Tract
47820	Unspecified Diseases of Pharynx
47826	Cyst of Pharynx or Nasophaynx
47829	Other Disease of Pharynx
4784	Polyp of Vocal Cords or Larynx
4785	Other Diseases of Vocal Cords
47870	Unspecified Diseases of Larynx
47879	Other Diseases of Larynx
4788	Upper Respiratory Tract Hypersensitivity Reaction., site unspecified
4789	Other and Unspecified Diseases of Upper Respiratory Tract
490	Bronchitis, not specified as acute or chronic
49100-49110	Chronic Bronchitis
49120	Obstructive Chronic Bronchitis without mention of exacerbation

4918	Other Chronic Bronchitis
4919	Unspecified Chronic Bronchitis
4920	Emphyematous Bieb
4928	Other Emphysema
49300	Extrinsic Asthma, without mention of status asthmaticus
49310	Intrinsic Asthma without mention of status asthmaticus
49320	Chronic Obstructive Asthma without mention of status asthmaticus
49390	Unspecified Asthma without mention of status asthmaticus
4940	Bronchiestasis without acute exacerbation
49500-50500	Extrinsic Allergic Alveolitis
5064	Chronic Respiratory Conditions due to fumes and vapors
5069	Unspecified Respiratory Conditions due to fumes and vapors
5081	Chronic and Other Pulmonary Manifestations due to radiation
5088	Respiratory Conditions due to Other Specified External Agents
5089	Respiratory Conditions due to Unspecified External Agents
514	Pulmonary Congestion and Hypostasis
515	Post-inflammatory Pulmonary Fibrosis
51600-51690	Other Alveolar and Parietoalveolar Pneumonopathy
51710-51780	Lung Involvement in conditions classified elsewhere
51810-51830	Intestitial or Compensatory Emphysema; Pulmonary Eosinophilia
5186	Allergic Bronchopulmonary Aspergillosis
51883-51889	Acute and Chronic Respiratory Failure; Other Diseases of Lungs not elsewhere classified
51910-51990	Other Diseases of Respiratory System
5200-5219	Disorders of Tooth Development and Eruption; Diseases of Hard Tissue of Teeth
52100-52109	Dental Carries
52510	Acquired Absence of Teeth
52512	Loss of Teeth Due to Peridontal Disease
52513	Loss of Teeth Due to Carries
52519	Other Loss of Teeth
53012	Acute Esophagitis
5220-5229	Diseases of Pulp and Periapical Tissues
5230-5239	Gingival and Periodontal Diseases
52400-52450	Major Anomalies of Jaw Size; Anomalies of Relationship of Jaw to Cranial Base
52460-52490	Temporomandibulat Joint Disorders; Dental Alveolar Anomalies
52500	Exfoliation of Teeth Due to Systemic Causes
52520-52590	Other Diseases and Conditions of the Teeth and Supporting Structures
52600-52690	Diseases of Jaws
52700-52790	Diseases of the Salivary Glands
52800-52820	Diseases of the Oral Soft Tissues, excluding Lesions Specific for Gingiva and Tongue;

52840-52890	Diseases of the Oral Soft Tissues, excluding Lesions Specific for Gingiva and Tongue;
52900-52990	Diseases and Other Conditions of the Tongue
53010-53019	Diseases of the Esophagus
53050-53060	Dyskinesia of Esophagus; Diverticulum of Esophagus, acquired
53081	Esophageal Reflux
53083	Esophageal Leukoplakia
53089	Other Disorder of Esophagus
5309	Unspecified Disorder of Esophagus
53170	Gastric Ulcer, Chronic without mention of hemorrhage, perforation or obstruction
53190	Gastric Ulcer, Unspecified as acute or chronic, without mention obstruction
53270	Duodenal Ulcer, Chronic, without mention of hemorrhage or perforation
53290	Duodenal Ulcer, Unspecified as acute or chronic, without mention of obstruction
53370	Peptic Ulcer, Chronic without mention of hemorrhage, perforation or obstruction
53390	Peptic Ulcer, Unspecified as acute or chronic, without mention of hemorrhage, perforation or obstruction
53470	Gastrojejunal Ulcer, Chronic without mention of hemorrhage, perforation or obstruction
53490	Gastrojejunal Ulcer, Unspecified as acute or chronic, without mention of hemorrhage, perforation or obstruction
53500	Acute Gastritis without mention of hemorrhage
53510	Atrophic Gastritis without mention of hemorrhage
53520	Gastric Mucosal Hypertrophy without mention of hemorrhage
53530	Alcoholic Gastritis without mention of hemorrhage
53540	Other Specified Gastritis without mention of hemorrhage
53550	Unspecified Gastritis and Gastroduodenitis without mention of hemorrhage
53560	Duodenitis without mention of hemorrhage
53600-53620	Achlorhydria; Acute Dilation of Stomach; Persistent Vomiting
53710-53720	Gastric Diverticulum; Chronic Duodental Ileus
53750-53760	Gastroptosis; Hourglass Stricture or Stenosis of Stomach
53781-53782	Pylorospasm; Anglodysplasia of Stomach and Duodenum without mention of hemorrhage
53789-53790	Other or Unspecified Disorder of Stomach and Duodenum
54300-54390	Other Diseases of Appendix
55090-55093	Inguinal Hernia, without mention of obstruction or gangrene
55500-55690	Regional Enteritis; Ulcerative Colitis
5589	Other and Unspecified Noninfectious Gastroenteritis and Colitis
56200-56201	Diverticulosis or Diverticulitis of Small Bowel without mention of hemorrhage

56210-56211	Diverticulosis or Diverticulitis of Colon without mention of hemorrhage
56400-56510	Functional Digestive Disorders and Other Specified Functional Disorders of Intestine, Anal Fissure or Fistula
56800-56880	Peritoneal Adhesions and Other Specified Disorders of Peritoneum
56882-56889	Peritoneal Effusion (chronic); Other and Unspecified Disorder of Peritoneum
5689	Unspecified Disorder of Peritoneum
56900-56920	Anal and Rectal Polyp; Stenosis of Rectum and Anus; Rectal Prolapse
56941-56949	Ulcer of Anus and Rectum; Anal or Rectal Pain; Other
56989-56990	Other and Unspecified Disorder of Intestine
5710	Alcoholic Fatty Liver
57120-57190	Chronic Liver Disease and Cirrhosis
57230-57280	Sequelae of Chronic Liver Disease
57300-57330	Other Disorders of Liver
57380-57390	Other Specified and Unspecified Disorders of Liver
5759	Unspecified Disorder of Gallbladder
5760	Postcholecystectomy Syndrome
57640-57690	Fistula of Bile Duct; Spasm of Sphincter of Oddi; Other Specified and Unspecified Diseases of Biliary Tract
57710-57790	Diseases of Pancreas
57900-57990	Intestinal Malabsorption
58100-58290	Nephrotic Syndrome; Other Specified Pathological Lesion in Kidney; Chronic Glomerulonephritis
58500-59001	Chronic Renal Failure; Disorders Resulting in Impaired Renal Function; Small Kidney of Unknown Cause; Chronic Pyelonephritis
5909	Infection of Kidney, Unspecified
591	Hydronephrosis
59300-59373	Other Disorders of Kidney and Ureter; Vesicoureteral Reflux
59389-59390	Other and Unspecified Disorders of Kidney and Ureter
59510-59590	Chronic and Other Interstitial Cystitis; Trigonitis; Cystitis in Diseases classified elsewhere; Other Specified Types of Cystitis
59600-59640	Other Disorders of Bladder
59651-59659	Other Functional Disorders of Bladder
59680-59690	Other and Unspecified Disorders of Bladder
59780-59789	Other Urethritis
59800-59890	Urethral Stricture due to infection
5990	Urinary Tract Infection, site not specified
59920-59940	Urethral Diverticulum, Caruncle; Urethral False Passage
59981-59990	Other Specified Disorders of Urethra and Urinary Tract
6000-60090	Hyperplasia of Prostate
6011	Chronic Prostatitis

6020	Calculus of Prostate
60220-60290	Atrophy of Prostate; Other Specified and Unspecified Disorders of Prostate
6023	Dysplasia of Prostate
6030	Encysted Hydrocele
6038	Other Specified types of Hydrocele
605	Redundant Prepuce and Phimosis
60600-60690	Infertility, male
6070	Leukoplakis of Penis
60784-60790	Impotence of Organic Origin; Other and Specified Disorders of Penis
60800-60810	Seminal Vesiculitis; Spermatocele
60830-60840	Atrophy of Testis; Other Inflammatory and Specified Disorders of Male Genital Organs
60881-60885	Other Specified Disorders of Male Genital Organs
60887	Retrograde Ejaculation
60889-60890	Other and Unspecified Disorder of Male Gential Organs
61000-61190	Benign Mammary Dyplasias; Other Disorders of Breast
6141	Chronic Salpingitis and Oophoritis
6142	Salpingitis and Oophoritis not specified as acute, subacute or chronic
6144	Chronic or Unspecified Parametritis and Pelvic Cellulitis
61460-61490	Pelvic Peritoneal Adhesions, female; Other Chronic Pelvic Peritonitis, female; Other Specified or Unspecified Inflammatory Diseases of Female Pelvic Organs and Tissues
61510-61590	Chronic and Unspecified Inflammatory Diseases of Uterus
61610-61620	Vaginitis and Vulvovaginitis; Cyst of Bartholin's Gland
61650-61651	Ulceration of Vulva
61680-61690	Other Specified and Unspecified Inflammatory Diseases of Cervix, Vagina, and Vulva
61700-61790	Endometriosis
61800-61890	Genital Prolapse
61900-61990	Fistulas involving Female Genital Tract
62000-62040	Noninflammatory Disorders Ovary, Fallopian Tube, and Broad Ligament
62080-62090	Other and Unspecified Noninflammatory Disorders of Ovary, Fallopian Tube, and Broad Ligament
62100-62350	Disorders of Uterus, not elsewhere classified; Noninflammatory Disorders of Cervix, Vagina
62370-62390	Polyp of Vagina; Other Specified and Unspecified Noninflammatory Disorders of Vagina
62400-62440	Noninflammatory Disorders of Vulva and Perineum
62460-62490	Polyp of Labia or Vulva; Other Specified or Unspecified Noninflammatory Disorders of Vulva and Perineum
62500-62590	Pain and Other Symptoms associated with Female Genital Organs

62600-62690	Disorders of Menstruation and Other Abnormal Bleeding from Female Genital Tract
62700-62790	Menopausal and Post Menopausal Disorders
62800-62890	Infertility, female
62900-62990	Other Disorders of Female Genital Organs
63100-63200	Missed Abortion; Other Abnormal Product of Conception
63790-63792	Unspecified Abortion without mention of complication
63890-63892	Failed Attempted Abortion without mention of complication
64300-64303	Mild Hyperemesis Gravidarum
64320-64393	Late, Other, Unspecified Vomiting of Pregnancy or Complicating Pregnancy
64510-64523	Late Pregnancy
64600-64603	Papyraceous Fetus
64610-64614	Edema or Excessive Weight Gain in Pregnancy without mention of hypertension
64620-64624	Unspecified Renal Disease in Pregnancy without mention of hypertension
64630-64633	Habitual Aborter
64640-64644	Peripheral Neuritis in Pregnancy
64650-64654	Asymptomatic Bacteriuria in Pregnancy
64660-64664	Infections of Genitourinary Tract in Pregnancy
64670-64673	Liver Disorders in Pregnancy
64680-64684	Other Specified Complications of Pregnancy
64690-64693	Unspecified Complications of Pregnancy
64790-64794	Unspecified Infection or Infestation affecting Conditions in the Mother
64890-64894	Other Current Conditions in the Mother
65500-65623	Known or Suspected Fetal Abnormality affecting management of mother
65650-65653	Poor Fetal Growth
65660-65663	Excessive Fetal Growth
65670-65673	Other Placental Conditions
65680-65683	Other Specified Fetal and Placental Problems
65690-65693	Unspecified Fetal and Placental Problems
65700-65730	Polyhydramnios
65800-65803	Oligohydramnios
65880-65883	Other Problems Associated with Amniotic Cavity and Membranes
65890-65893	Unspecified Problems Associated with Amniotic Cavity and Membranes
65900-65903	Failed Mechanical Induction
65910-65913	Failed Mechanical or Unspecified Induction
65940-65943	Grand Multiparity
65950-65953	Elderly Primigravida
65960-65963	Elderly Multigravida

65980-65983	Other Specified Indications for Care or Intervention Related To Labor and Delivery
65990-65993	Unspecified Indications for Care or Intervention Related To Labor and Delivery
66580	Other Specified Obstetrical Trauma
66590	Unspecified Obstetrical Trauma
67500	Infections of Nipple
67600-67604	Retracted Nipple
67610-67614	Cracked Nipple
67630-67634	Other and Unspecified Disorder of Breast
67640-67644	Failure of Lactation, Postpartum Condition or Complication
67650-67654	Suppressed Lactation
67660-67664	Galactorrhea
67680-67684	Other Disorders of Lactation
67690-67694	Unspecified Disorders of Lactation
677	Late Effect of Complication of Pregnancy, Childbirth and the Puerperium
68000-68090	Carbuncle and Furuncle
68100-68102	Cellulitis and Abscess of Finger
68110-68111	Cellulitis and Abscess of Toe
6819	Cellulitis and Abscess of Unspecified Digit
68200-68290	Other Cellulitis and Abscess
683	Acute Lymphadenitis
684	Impetigo
68500-68510	Pilonidal Cyst, with or without mention of Abscess
68600-68609	Pyoderma
6861	Pyogenic Granuloma
68680-68690	Other and Unspecified Local Infections of Skin and Subcutaneous Tissue
69010-69012	Seborrheic Dermatits
69018	Other Seborrheic Dermatits
69080	Other Erythematosquamous Dermatosis
6910	Diaper or Napkin Rash
6918	Atopic Dermatitis and related conditions
69201-69260	Contact Dermatitis and Other Eczema
69270-69279	Contact Dermatitis due to solar radiation
69280-69290	Contact Dermatitis due to other specified agent
69300-69390	Dermatitis due to substances taken internally
69400-69450	Bullous Dermatoses
69460-69490	Benign Mucous Membrane Pemphogoid
69500-69590	Erythematous Conditions
69600-69680	Psorasis and Similar Disorders
69700-69790	Lichen
69800-69890	Pruritus and Other Related Conditions; Corns and Callosities
700	Corns and Callosities

70100-70190	Other Hypertropic and Atropic Conditions of Skin
70200-70280	Other Dermatoses; Seborrheic Keratosis
70300-70390	Diseases of Nail
70400-70490	Alopecia
70500-70590	Disorders of Sweat Glands
70600-70690	Diseases of Sebaceous Glands
7070	Decubitus Ulcer
70710-70790	Ulcer of Lower Limbs, except decubitus
70800-70890	Uticaria
70900-70909	Dyschromia
70910-70990	Other Disorders of Skin and Subcutaneous Tissue
71000-71090	Diffuse Disease of Connective Tissue
71100-71109	Pyogenic Arthritis
71110-71119	Arthropathy Associated with Reiter's Disease and Nonspecific Urethritis
71120-71129	Arthropathy in Bechet's Syndrome
71130-71139	Postdysenteric Arthropathy
71140-71149	Arthropathy Associated with other Bacterial Diseases
71150-71159	Arthropathy Associated with other Viral Diseases
71160-71169	Arthropathy Associated with Mycoses
71170-71179	Arthropathy Associated with Helminthiasis
71180-71189	Arthropathy Associated with Other Infections and Parasitic Diseases
71190-71199	Unspecified Infective Arthritis
71210-71219	Chondrocalcinosis Due to Dicalcium Phoshate Crystals
71220-71229	Chondrocalcinosis Due to Pyrophosphate Crystals
71230-71239	Chondrocalcinosis, Unspecified
71280-71289	Other Specified Crystal Arthropathies
71290-71299	Unspecified Crystal Arthropathy
71300-71380	Arthropathy Associated with other disorders classified elsewhere
71400-71420	Rheumatoid Arthritis and Other Inflammatory Polyarthropathies
71430-71440	Juvenile Chronic Polysrthritis
71481-71490	Other Specified Inflammatory Polyarthropathies
71500-71598	Osteoarthrosis and Allied Disorders
71600-71609	Kaschin-Beck Disease
71620-71629	Allergic Arthritis
71630-71639	Climateric Arthritis
71640-71649	Transient Arthropathy
71650-71659	Unspecified Polyarthropathy or Polyarthritis
71660-71668	Unspecified Monoarthritis
71680-71689	Other Specified Arthropathy
71690-71699	Arthropathy, unspecified
71781-71790	Other and Unspecified Internal Derangement of Knee
71800-71819	Other Derangement of Joint; Articular Cartilage Disorder; Loose body in Joint

71830-71859	Recurrent Dislocation of Joint; Contracture of Joint; Anklosis of Joint
71870-71899	Other Joint Derangement, not elsewhere classified or unspecified
71900-71909	Effusion of Joint
71920-71949	Villonodular Synovitis; Palindromic Rheumatism; Pain in Joint
71950-71999	Stiffness in Joint, not elsewhere classified; Other Symptoms referable to Joint; Difficulty in Walking; Other Specified and Unspecified Disorders of Joint
72081	Inflammatory Spondylopathies in disease classified elsewhere
72089-72090	Other and Unspecified Inflammatory Spondylopathy
72100-72130	Spondylosis and Allied Disorders
72141-72191	Thoracic or Lumbar or Unspecified Site Spondylosis without Myelopathy
7220	Displacement of Cervical Intervertebral Disc with Myelopathy
72210-72220	Displacement of Thoraic or Lumbar Intervertebral Disc with Myelopathy
72230-72239	Schmorl's Nodes
72240-72260	Degeneration of Thoraic, Lumbar or Site Unspecified Intervertebral Disc
72270-72273	Intervertebral Disc Disorder with Myelopathy
72280-72283	Postlaminectomy Syndrome
72290-72293	Other and Unspecified Disc Disorder
72300-72390	Other Disorders of Cervical Region
72400-72460	Spinal Stenosis, other than cervical in cervical region
72470-72479	Disorders of Coccyx
72480-72490	Other and Unspecified Symptoms or Disorders referable to Back
725	Polymyalgia Rheumatica
72601-72619	Peripheral Enthesopathies and Allied Syndromes
7262	Other Affections of Shoulder Region, not elsewhere classified
72630-72633	Enthesopathy of Elbow; Medial and Lateral Epicondyitis; Olecranon Bursitis
72639	Other Enthesopathy of Elbow Region
7264	Enthesopathy of Wrist, Carpus
7265	Enthesopathy of Hip Region
72660-72669	Enthesopathy of Knee
72670-72673	Enthesopathy of Ankle and Tarsus; Achilles Bursitis or Tendinitis; Tibialis Tendinitis; Calcaneal Spur
72679-72680	Other Enthesopathy of Ankle and Tarsus; Other Peripheral Enthesopathies
72690	Enthesopathy of unspecified site
72691	Exostosis of unspecified site
72700-72709	Synovitis and Tenosynovitis
7271	Bunion
7272	Specific Bursitides Often of Occupational Origin

7273	Other Bursitis
72740-72749	Ganglion and Cyst of Synovium, Tendon, and Bursa
72781-72790	Other Disorders of Synovium, Tendon, and Bursa
72810	Muscular Calcification and Ossification
72819	Other Muscular Calcification and Ossification
72820-72860	Muscular Wasting and Disuse Atrophy, not elsewhere classified; Other Specific Muscle Disorders; Laxity of Ligament; Hypermobility Syndrome; Contracture of Palmar Fascia
72871-72879	Other Fibromatoses
72882-72890	Other and Unspecified Disorders of Muscle, Ligament, and Fascia
72900-72920	Other Disorders of Soft Tissues
72930-72939	Panniculitis, Unspecified Site, Hypertrophy of Fat Pad, Knee; Other Site
7294	Fasciitis, Unspecified
7295	Pain in Limb
7296	Residual Foreign Body in Soft Tissue
72981-72990	Other Musculoskeletal Symptoms Referable to Limbs; Other and Unspecified Disorders of Soft Tissue
73010-73019	Chronic Osteomyelitis
73020-73029	Unspecifed Osteomyelitis
73030-73039	Periostitis without mention of Osteomyelitis
73070-73079	Osteopathy Resulting from Poliomyelitis
73080-73089	Other Infections Involving Bone in diseases classified elsewhere
73090-73099	Unspecified Infection of Bone
73100-73180	Osteitis Deformans and Osteopathies Associated with Other Disorders classified elsewhere
73200-73290	Osteochondropathies
73300-73309	Osteoprosis
73320-73329	Cyst of Bone
7333	Hyperostosis of Skull
73340-73349	Aseptic Necrosis of Bone
7335	Osteitis Condensans
7336	Tietze's Disease
7337	Algoneurodystrophy
73381-73382	Malunion and Nonunion of Fracture
73390-73392	Disorder of Bone and Caritlage, Unspecified; Arrest of Bone Development or Growth
73399	Other Disorders of Bone and Cartilage
734	Flat Foot
73500-73590	Acquired Deformities of Toe
73600-73609	Acquired Deformities of Forearm, excluding fingers
7361	Mallet Finger
73620-73629	Other Acquired Deformities of Finger
73630-73639	Acquired Deformities of Hip

73641-73660	Genu Vaigum or Varum (acquired)
73670-73679	Other Acquired Deformities of Ankle and Foot
73681-73689	Acquired Deformities of Other Parts of Limb
7369	Acquired Deformity of Limb, site unspecified
7370	Adolescent Postural Kyphosis
73710-73719	Kyphosis (acquired)
73720-73729	Lordosis (acquired)
73730-73739	Kyphoscoliosis and Scoliosis
73740-73790	Curature of Spine Associated with other conditions
7380	Other Acquired Deformity of Nose
73810-73812	Other Acquired Deformity of Head; Zygomatic Hyperplasia or Hypoplasia
73819	Other Specified Deformity
7382	Acquired Deformity of Neck,
7383	Acquired Deformity of Chest and Rib
7384	Acquired Spondylolisthesis
7385	Other Acquired Deformity of Back or Spine
7386	Acquired Deformity of Pelvis
7387	Cauliflower Ear
7388	Acquired Deformity of Other Specified Site
7389	Other Acquired Deformity of Unspecified Sites
73900-73990	Nonallopathic Lesions, not elsewhere classified
74000-74020	Anencephalus and Similar Anomalies
74100-74193	Spina Bifida with or without mention of Hydrocephalus
74200-74240	Other Congenital Anomalies of Nervous System
74251-74259	Other Specified Anomalies of Spinal Cord
74280-74290	Other Specified and Unspecified Anomalies of Brain, Spinal Cord or Nervous System
74300-74306	Anophthalmos
74310-74312	Microphthalmos
74320-74322	Buphthalmos
74330-74339	Congenital Cataract and Lens Anomalies
74341-74349	Coloboma and Other Anomalies of Anterior Segment
74351-74359	Congenital Anomalies of Posterior Segment
74361-74369	Congenital Anomalies of Eyelids, Lacrimal System, and Orbit
74380-74390	Other Specified and Unspecified Anomaly of Eye
74400-74409	Anomalies of Ear causing Impairment of Hearing
7441	Accessary Auricle
74421-74429	Other Specified Anomalies of Ear
7443	Unspecified Anomalies of Ear
74441-74449	Branchial Cleft Cyst or Fistula; Perauricular Sinus
7445	Webbing of Neck
74481-74489	Other Specified Anomalies of Face and Neck
7449	Unspecified Anomalies of Face and Neck
7450	Bulbus Cordis Anomalies and Anomalies of Cardiac Septal

	Closure
74512-74519	Correction Transposition of Great Vessels; Other
74560-74569	Endocardial Cushion Defects
7457	Cor Biloculare
74580-74590	Other and Unspecified Defect of Septal Closure
74720-74729	Other Anomalies of Aorta
7473	Anomalies of Pulmonary Artery
74740-74749	Anomalies of Great Viens
7475	Absence or Hypoplasis of Umbilical Artery
74760-74769	Other Anomalies of Peripheral Vascular System
74781-74789	Other Specified Anomalies of Circulatory System
7479	Unspecified Anomaly of Circulatory System
74800-74850	Unspecified Anomalies of Respiratory System
74860-74890	Other Anomalies of Lung
74900-74904	Cleft Palate
74910-74914	Cleft Lip
74920-74925	Cleft Palate with Cleft Lip
75000-75019	Other Congenital Anomalies of Upper Alimentary Tract
75021-75029	Other Specified Anomalies of Mouth and Pharynx
7503	Tracheoesophageal Fistula, Esophageal Atresia and Stenosis
7504	Other Specified Anomalies of Esophagus
7505	Congenital Hypertonic Pyloric Stenosis
7506	Congenital Hiatus Hernia
7507	Other Specified Anomalies of Stomach
7508	Other Specified Anomalies of Upper Alimentary Tract
7509	Unspecified Anomaly of Upper Alimentary Tract
75100-75150	Other Congenital Anomalies of Digestive System
75160	Anomalies of Gallbladder, Bile Ducts, and Liver
75162-75169	Congenital Cystic Disease of Liver; Other Anomalies of Gallbladder, Bile Ducts and Liver
7517	Anomalies of Pancreas
7518	Other Specified Anomaly of Digestive System
7519	Unspecified Anomalies of Digestive System
7520	Anomalies of Ovaries
75210-75219	Anomalies of Fallopian Tubes and Broad Ligament
7522	Doubling of Uterus
7523	Other Anomalies of Uterus
75240-75242	Unspecified Anomaly or Embroyonic cycst of Cervix, Vagina, and External Female Genitalia; Imperforate Hymen
75249	Other Anomalies of Cervix, Vagina, and External Female Genitalia
75251-75252	Undescended and Retractable Testicle
75261-75269	Hypospadias and Epispadias and Other Penile Anomalies
7527	Indeterminate Sex and Pseudohermaphroditism
7528	Other Specified Anomalies of Genital Organs

7529	Unspecified Anomalies of Genital Organs
7530	Renal Agenesis and Dysgenesis
75310-75319	Cystic Kidney Disease
75320-75329	Obstructive Defects of Renal Pelvis and Ureter
7533	Other Specified Anomalies of Kidney
7534	Other Specified Anomalies of Ureter
7535	Exstropy of Urinary Bladder
7536	Atresia and Stenosis of Urethra and Bladder Neck
7537	Anomalies of Urachus
7538	Other Specified Anomalies of Bladder and Urethra
7539	Unspecified Anomaly of Urinary System
75400-75420	Certain Congenital Musculoskeletal Deformities
75430-75435	Congenital Dislocation of Hip
75440-75444	Congenital Genu Recurvatum and Bowing of Bones of Leg
75450-75459	Varus Deformities of Feet
75460-75469	Valgas Deformities of Feet
75470-75479	Other Deformities of Feet
75481-75489	Other Specified Nonteratogenic Anomalies
75500-75502	Poldactyly
75510-75514	Syndactyly
75520-75529	Reduction Deformities of Upper Limb
75530-75539	Reduction Deformities of Lower Limb
7554	Reduction Deformities, Unspecified Limb
75550-75559	Other Anomalies of Upper Limb, including Shoulder Girdle
75560-75569	Other Anomalies of Lower Limb, including Pelvic Girdle
7558	Other Specified Anomalies of Unspecified Limb
7559	Unspecified Anomaly of Unspecified Limb
7560	Anomalies of Skull and Face Bones
75610-75640	Anomalies of Spine
75650-75659	Osteodystrophies
7566	Anomalies of Diaphragm
75670-75679	Anomalies of Abdominal Wall
75681-75689	Other Specified Anomalies of Muscle, Tendon, Fascia, and Connective Tissues
7569	Other and Unspecified Anomalies of Musculoskeletal System
75700-75720	Congenital Anomalies of the Integument
75731	Congenital Ectodermal Dysplasia
75732	Vascular Hamartomas
75733	Congenital Pigmentary Anomalies of Skin
75739	Other Congenital Anomalies of Integument
7574	Specified Anomalies of Hair
7575	Specified Anomalies of Nails
7576	Specified Anomalies of Breast
7578	Other Specified Anomalies of Integument
7579	Unspecified Anomalies of the Integument

75800-75870	Chromosomal Anomalies
75881-75889	Other Conditions due to Chromosome Anomalies
7589	Conditions Due to Anomaly of Unspecified Chromosome
75900-75970	Other and Unspecified Congenital Anomalies
75981-75989	Other Specified Anomalies
75999	Congenital Anomaly, unspecified
7793	Feeding Problems in Newborn
7796	Termination of Pregnancy (fetus)
77980-77990	Other Specified and Unspecified Conditions originating in the perinatal period
7801	Hallucinations
7804	Dizziness and Giddiness
78050-78059	Sleep Disturbances
7806	Fever
78071	Malaise and Fatigue
78079	Other Malaise and Fatigue
7808	Hyperhidrosis
78090-78099	Other General Symptoms
7818	Neurologic Neglect Syndrome
78191-78199	Other Symptoms Involving Nervous and Musculoskeletal Systems
78200-78240	Symptoms Involving Skin and Integumentary Tissue
78261-78262	Pallor and Flushing
7827	Spontaneous Ecchynoses
7828	Changes in Skin Texture
7829	Other Symptoms Involving Skin and Integumentary Tissue
78300-78390	Symptoms concerning Nutrition, Metabolism and Development
78400-78420	Symptoms Involving Head and Neck
78440-78449	Voice Disturbance
7845	Other Speech Disturbance
78460-78469	Other Symbolic Dysfunction
7847	Epistaxis
7849	Other Symptoms Involving Head and Neck
7852	Undiagnosed Cardiac Murmurs
7853	Other Abnormal Heart Sounds
7856	Enlargement of Lymph Nodes
7859	Other Symptoms involving Cardiovascular System
78600-78602	Dyspnea and Respiratory Abnormalities
78605	Shortness of Breath
78606	Tachypnea
78607	Wheezing
78609	Other Symptoms involving Respiratory System
7862	Cough
7864	Abnormal Sputum
78650	Chest Pain, Unspecified

78652	Painful Respiration
78659	Other Symptoms of Chest Pain
7866	Swelling, Mass, or Lump in Chest
7867	Abnormal Chest Sounds
7868	Hiccough
7869	Other Symptoms involving Respiratory System and Chest
78701-78703	Symptoms involving Digestive System
7871	Heartburn
7872	Dyphagia
7873	Flatulence, Erutation, and Gas Pain
7874	Visible Peristalsis
7875	Abnormal Bowel Sounds
7876	Incontinence of Feces
7877	Abnormal Feces
78791-78799	Other Symptoms Involving Digestive System
7881	Dysuria
78820	Retention of Urine, Unspecified
78821	Incomplete Bladder Emptying
78829	Other Specified Retention of Urine
78830-78839	Incontinence of Urine
78841-78843	Frequency of Urination and Polyuria
7885	Oliguria and Anuria
78861-78869	Other Abnormality of Urination
7888	Extravasation of Urine
7889	Other Symptoms of Urine
78900-78909	Other Symptoms Involving Abdomen and Pelvis
7891	Hepatomegaly
7892	Splenomegaly
78930-78939	Abdominal or Pelvic Swelling, Mass or Lump
78940-78949	Abdominal Rigidity
7895	Ascites
78960-78969	Abdominal Tenderness
7899	Other Symptoms Involving Abdomen and Pelvis
79001-79060	Nonspecific Findings on Examination of Blood
7908	Viremia, unspecified
79091-79099	Other Nonspecific on Examination of Blood
79100-79190	Nonspecific on Examination of Urine
7924	Abnormal Findings on Examination of Saliva
7925	Cloudy (hemodialysis) (peritoneal) Dialysis Effluent
7929	Other Nonspecific Abnormal Findings in Body Substances
79300-79390	Nonspecific Abnormal Findings on Radiological and Other Exam of Body Structure
79400-79409	Nonspecific Abnormal Results of Function Studies
79410-79419	Peripheral Nervous System and Special Senses
7942	Pulmonary

79430-79439	Cardiovascular
7944	Kidney
7945	Thyroid
7946	Other Endocrine Function Study
7947	Basal Metabolism
7948	Liver
7949	Other
79500-79560	Nonspecific Abnormal Histological and Immunological Findings
79571	Nonspecific Serology Evidence of Human Immunodeficiency Virus
79579	Other and Unspecified Nonspecific Immunological Findings
79600-79690	Other Nonspecific Abnormal Findings
797	Senility without Mention of Psychosis
7992	Nervousness
7993	Debility, unspecified
7994	Cachexia
7998	Other Ill-Defined Conditions
7999	Other Unknown or Unspecified Cause
84600-84899	Sprains and Strains
90500-90590	Late Effects of Musculoskeletal and Connective Tissue Injuries
90600-90690	Late Effects of Injuries to Skin and Subcutaneous Tissues
90700-90790	Superficial Insect Bite, Nonvenomous, without mention of Infection on Face, Neck, or Scalp except Eye
90800-90890	Late Effects of Other and Unspecified Injuries
90900-90990	Late Effects of Other and Unspecified External Causes
91000-91090	Superficial Injury to Face, Neck or Scalp except Eye
91100-91190	Superficial Injury of Trunk
91200-91290	Superficial Injury of Shoulder and Upper Arm
91300-91390	Superficial Injury of Elbow, Forearm, and Wrist
91400-91490	Superficial Injury of Hand(s) except Finger(s) alone
91500-91590	Superficial Injury of Finger(s)
91600-91690	Superficial Injury of Hip, Thigh, Leg, and Ankle
91700-91790	Superficial Injury of Foot and Toe(s)
91900-91990	Superficial Injury of Other, Multiple, and Unspecified Sites
92200-92220	Contusion of Trunk
92230-92290	Contusion of Back
92300-92309	Contusion of Shoulder and Upper Arm
92310-92311	Contusion of Elbow and Forearm
92320-92321	Contusion of Wrist and Hand(s), Except Finger(s) alone
9233	Contusion of Finger
92380-92390	Contusion of Multiple Sites and Unspecified Part of Upper Limb
92400-92401	Contusion of Hip and Thigh
92410-92411	Contusion of Knee and Lower Leg
92420-92421	Contusion of Ankle and Foot, excluding Toe(s)
9243	Contusion of Toe

9244	Contusion of Multiple Sites of Lower Limb
9245	Contusion of Unspecified Part of Lower Limb
9248	Contusion of Multiple Sites, not elsewhere classified
9249	Contusion of Unspecified Site
9952	Unspecified Adverse Effect of Drug, Medicinal and Biological Substance
9990-9999	Complications or Medical Care, not elsewhere classified
V0100-V4589	All in this range
V4690-V6120	All in this range
V6129-V7130	All in this range
V717	All in this range
V7189-V8299	All in this range
V8301-**V8389**	All in this range
E9600	Unarmed Fight or Brawl
E969	Late Effects of Injury purposely Inflicted by Other Person
E999	Late Effects of Injury due to War Operations

Client Last Name _____ First Name _____ MI _____

Street Address _____

City _____ State _____ Zip _____ City/County of Residence _____

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
MATERNAL CARE COORDINATION RECORD

Medicaid #		**COORDINATOR NAME**
Birthdate	Occupation	**Coordinator Agency**
Marital Status	Race	**Coordinator Address**
Education Level	DMAS Provider #	**First MICC Contact** Date (D/M/Y)
# of Live Births	Abortion	**Assessment Completed** Date (D/M/Y)
Miscarriages	Stillbirths	**Service Plan Completed** Date (D/M/Y)
Client Home Phone		Work Phone
Emergency Contact		Emergency Contact Phone
Primary Care MD		Primary Care Phone
EDC	Hospital	Wks. gestation when prenatal care began

PSYCHOLOGICAL ASSESSMENT

	Yes	No		Yes	No		Yes	No
1. Previous poor pregnancy exp.			8. Conflict/violence in home			15. Housing needs		
2. Poor support system			9. Family has urgent health needs			16. Transportation need		
3. Significant anxiety			10. Insufficient funds for food			17. School needs		
4. Drug usage			11. Difficulty obtaining food stamps			18. Employment need		
5. Alcohol usage			12. Poor planning ability			19. Homeless		
6. Tobacco usage			13. Poorly motivated			20. Neglect		
7. Religious/ethnic factors affecting pregnancy			14. Childcare needs/poor parenting knowledge			21. Mental retardation/ emotional problems		

GENERAL MEDICAL ASSESSMENT

	Yes	No		Yes	No		Yes	No
1. Multiple gestation			4. Medical condition affecting pregnancy			7. Limited access to care		
2. Prior preterm <5 ½ lb>			5. Lack of risk knowledge/poor pregnancy information			8. Advanced maternal age >35		
3. History of genetic disorder			6. Previous fetal death			9. Multiple medical providers		

NUTRITIONAL ASSESSMENT

	Yes	No		Yes	No		Yes	No
1. Pregnancy overwgt.			5. Medical condition affects diet			9. Poor basic diet info		
2. Pregnancy underwgt.			6. Special diet prescribed			10. Inadequate cooking facility		
3. Inadequate wgt. gain			7. Nausea/Vomiting			11. Age 18 or younger		
4. Excessive wgt. gain			8. Food cravings/pica			12. Anemia		

SUBSTANCE ABUSE USAGE PRIOR TO START OF PREGNANCY

	Days/ Weeks	Times/ Day		Days/ Weeks	Times/ Day		Days/ Weeks	Times/ Day
1. Alcohol			4. Marijuana/hashish			7. Inhalants		
2. Cocaine/crack			5. Sedatives/tranquilizers			8. Tobacco/cig		
3. Narcotics/heroin/codeine			6. Amphetamines/diet pills			9. Other		

SUBSTANCE ABUSE USAGE AT CURRENT POINT IN PREGNANCY

	Days/ Weeks	Times/ Day		Days/ Weeks	Times/ Day		Days/ Weeks	Times/ Day
1. Alcohol			4. Marijuana/hashish			7. Inhalants		
2. Cocaine/crack			5. Sedatives/tranquilizers			8. Tobacco/cig		
3. Narcotics/heroin/codeine			6. Amphetamines/diet pills			9. Other		

CLIENT REFERRALS	**Date**	**Outcome**		**Date**	**Outcome**	**POSTPARTUM REFERRAL**	**Date**
WIC			Homemaker			Family Planning	
Nutrition Counseling			Tobacco Cess.			EPSDT	
Parenting/Child			Substance Abuse			Infant WIC	
						DSS Medicaid Eligibility Re-determination	

SIGNIFICANT FINDINGS

DMAS-50 rev. 10/02 COORDINATOR SIGNATURE _____ DATE _____

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PREGNANCY OUTCOME REPORT

1. Last Name _____ 2. First _____ 3. MI _____ 4. Other Last Name _____

5. Date of Birth (M/D/Y) _____ 6. City/County of Residence _____ 7. Race: Enter appropriate number in space provided. _____

8. Medicaid # _____ 8. Previous # if applicable _____

9. Provider # _____ 10. Provider Name _____
Address _____
_____

1. White
2. Black
3. Am. Indian
4. Asian
5. Hispanic
6. Other_____

11. Enter number of reason recipient is no longer requiring service _____

1. Pregnancy ended	4. Lost to follow-up	7. Died
2. Dropped out of prenatal care	5. Eligibility cancelled	8. Moved
3. Transfer to other MICC agency	6. Problem resolved	9. Other (Specify):

12. Pregnancy Outcome: _____

Instruction: Enter pregnancy outcome number in the space above only if the answer to item 11 is "1. PREGNANCY ENDED"

1. Live birth	3. Therapeutic abortion	5. Fetal death
2. Spontaneous abortion	4. Elective abortion	6. Other:

13. Infant's Live Birth Data
Instruction: Complete item 13 only if answer to item 12 is "1. LIVE BIRTH"

	INFANT #1	INFANT # 2
Birth Weight lbs. and ozs.		
Birth Date		
APGAR Score 1 min **5 min**		

14. Weeks gestation at time of birth _____

15. Infant Risk Screen

a. Has Physician completed risk screen?	1-Yes	2-No	**c.** If yes, has the infant been referred to care coordination?	1-Yes	2-No
b. If yes, was the infant classified as " high risk"?	1-Yes	2-No	**d.** If yes, was the infant born with morbidity?	1-Yes	2-No
16. Is the Infant receiving EPSDT services?	1-Yes	2-No	**17. Is the infant receiving WIC services?**	1-Yes	2-No

18. Enter number of weeks gestation when mother began prenatal care _____

19. Total number of prenatal visits by mother during this pregnancy _____

20. Did mother receive WIC during pregnancy?	1-Yes	2-No	**21. Did mother receive postpartum or family planning exam?**	1-Yes	2-No

22. Client Needs
Instruction: Indicate needs that were met through care coordinator assistance by entering "1" in the appropriate space(s).
Indicate client needs that were not met at the completion of care coordination by entering "2" in the space(s).

1. Child Care		5. Homemaker Ser.		9. Psychological		13. Smoking Cessation	
2. Food Stamps		6. Home Health Ser.		10. Job Training		14. Glucose Monitoring	
3. Housing		7. Employment		11. Transportation		15. Parenting/Childbirth	
4. Nutrition Ser.		8. School Enrollment		12. Substance Abuse Treatment		16. Family Planning	

12. Substance abuse at time of delivery
INSTRUCTION: Item 23 must be completed if substance abuse was indicated on Maternal Care Coordination Record (DMAS-50)

	# Days/Week	# Times/Day		# Days/Week	# Times/Day
Alcohol			Sedatives/Tranquilizers		
Cocaine/Crack			Amphetamines/Diet Pills		
Narcotics/Heroin			Inhalants/Glue		
Marijuana/Hashish			Tobacco/Cigarettes		
			Other (Specify):		

Coordinator's Signature _____ Date _____